

CITIZENS LEAGUE REPORT

MEETING THE CRISIS IN INSTITUTIONAL CARE:
Toward better choices, financing and results

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INTRODUCTION

From the outset the reader will be struck by the magnitude of the task which the League's board assigned and which this committee has undertaken. Briefly, our charge was to:

"Examine the question of relying more in coming years on conventional living arrangements, as distinguished from institutions, in providing care for people, either because the institutional approach may be less satisfactory for the benefit of the individual or because fewer funds will be available to support institutionalization"

Many populations are "institutionalized" in Minnesota. One of the purposes of our study was to sample how broadly the institutional approach is used in our state. To answer that question, we examined the manner in which care is provided to five different populations. They included the disabled elderly, the mentally retarded, the mentally ill, the chemically dependent and children involved in the juvenile justice and child welfare systems. We could have added other populations to our study such as the physically disabled, the handicapped and the adult correctional population. But we judged these sectors to be beyond the capacity of this study.

Examining any one of these populations in light of our charge would have been more than enough for any committee. But our committee, acting in what we believed to be the spirit of our charge, took a different approach. We decided early on to take a cross-systems look at problems in order to determine whether there was a common set of issues which bound these disparate populations together

We adopted an integrated approach for several reasons. First, each of the various systems overlaps in significant ways. Some mentally ill people are placed in nursing homes or treatment facilities for chemical dependency. Mentally retarded people can be inappropriately placed in nursing homes as well as entangled in the juvenile justice system. And, increasingly, researchers are documenting that there is a "hidden juvenile justice system" in which juveniles are placed in secure facilities for the mentally ill or chemically dependent.

Secondly, public policy has rarely looked at the interrelationships between these systems and serious problems have been occasioned by that oversight. Currently, for example, the passage of the new federal hospital reimbursement system is sure to provide hospitals with incentives to discharge people earlier. What then will happen to discharged elderly patients in a state where the nursing home occupancy rate is over 90 percent and public caps have been placed on nursing home construction and expansion?

Finally, it is clear that recent dramatic increases in the state's welfare expenditures cannot be sustained over time. If the public sector is to restrain the growth of these costs, substantial attention must be given to their underlying institutional nature. In fiscal year 1982, the Minnesota Department of Public Welfare had a total budget of \$756.1 million. Of that total, 20 percent was spent on institutional services for the mentally ill, the mentally retarded and the chemically dependent.

But that figure appears misleadingly small unless it is understood that within the state's medical assistance program (which accounts for nearly half of all welfare expenditures), fully 82 percent of all vendor payments are also "institutional" in the sense that they are received by hospitals and nursing homes.

In taking a cross-systems approach, we were not unmindful of the substantial differences the populations and the treatment systems which serve them. Sometimes care is delivered in an institutional or residential facility on a long-term basis. This is often the case for the elderly in nursing homes, the mentally retarded in state hospitals and Intermediate Care Facilities for the Mentally Retarded (ICF-MR) and some mentally ill persons and juveniles. But this is not always the case. CD (Chemical Dependency) treatment, for example, is usually completed in a shorter period of time. Sometimes the condition precipitating treatment is chronic in nature as it is for the disabled elderly and the mentally retarded. Chemical dependency or mental illness may or may not be a chronic condition depending upon the individual. Juveniles often become exposed to the juvenile justice system through chronic behavior but also for a variety of other reasons - not all of which, incidentally, may be attributed to them. (Child abuse for example).

There are also substantial differences within each of the populations as well as across them. These may be differences in the intensity of treatment,, kinds of treatment, etc. Treatment for some populations is a voluntary process while for some others it is seen as an involuntary or even adversarial process. Nor is treatment aimed at the same outcome for each population. For example, total rehabilitation leading to a return to independent living is not a realistic alternative for the frail elderly even though it may be an appropriate objective for some of the other populations. Some populations (juveniles, the chemically dependent, the mentally ill) may eventually need little or no continued professional intervention or assistance. While others (many elderly, the mentally retarded and the severely mentally ill) may require such assistance for the rest of their lives.

Because we sought to take a cross-systems look at these populations, some important terms must be defined from the outset. While it is true that Minnesota has made substantial progress in "deinstitutionalizing" certain populations, our major criticism of these systems is that this process has not gone far enough. Too often people have been discharged from a private or state hospital into a "community" residential facility that is only slightly less restrictive than their former setting. Too often community care unnecessarily fosters the same kind of dependency on professionals that is characteristic of institutional settings. Rarely is the person enabled or encouraged to be more self-sufficient, to return home or to receive care by family and friends rather than paid professionals.

We recognize that "institutional" care will always be needed by some - but their numbers are far fewer than those which are housed there today. We also recognize that some residential community facilities, particularly the smaller, intimate settings need to be preserved for those occasions when the family, or other non-institutional alternatives (relatives, neighbors, foster family), cannot be used to meet an individual's needs. But we also believe that these two systems need to be challenged to do more to free people altogether from unnecessary residential care.

Thus, for the purposes of this report, the term "residential" will be used to characterize both highly restrictive (state hospitals, private hospitals, state training schools) and somewhat less restrictive "community" facilities. In short, our use of the term residential covers all large (i.e., more than 10 people) facilities in which people receive housing and care under one roof on an intensive, 24-hour a day basis.

Some may find our definition of the term "residential" inappropriate. What we have here characterized as occasionally problematic others have consistently praised as a virtue. Nonetheless, we suggest that the definition is useful in reviewing present practices.

Despite the differences in the populations served by residential care, there are some remarkable similarities in the care provided in such facilities. In each, for example:

- Care is delivered by formal networks of professionals as opposed to informal networks of families, friends and neighbors.
- Care is delivered principally as a service rather than through love, obligation, etc. (though clearly many professionals imbue their work with these qualities.)
- Care is delivered for a price, as an economic transaction.
- Care is received outside the home.
- People reside outside their homes while receiving care. (As a result, "service" can be divided into two parts – housing and care.)
- The residential nature of the care, however unintended, in fact does tend to confine, limit, or restrict residents' behavior, certainly limiting personal liberties.
- Care is delivered when personal capacity to care for oneself or to have family, neighbors, friends care for the individual be come limited or exhausted.
- Care tends to follow the medical model. (This is clear in every system except the juvenile justice system. But there too the judge acts as physician in "diagnosing" the problem and pre-prescribing the appropriate remedy, often in medical terms. Such "treatment" is not intended to punish but rather to be restorative in nature. Although the juvenile justice system is beginning to move towards a punishment/accountability model today, the dominant thinking in that system remains wedded to medical precepts.)

As we looked more closely at existing arrangements of providing care and shelter to these populations, we began to question why it was necessary for them to actually live at the same facility in which they receive care. What benefits were derived from this arrangement? What detrimental effects occur? Why is it that in the majority of cases housing is considered inseparable

care? Why, in sum, has the deinstitutionalization movement stopped short of allowing most people who need special service to leave residential facilities altogether?

The product of such inquiries was further questions about why the systems are structured as they are. Interestingly enough, these same issues are beginning to comprise the "reform" agenda of the systems we examined. Consider, for example, the following similarities:

- In each system there is a growing informal consensus that there is too much use being made, often indiscriminately, of residential care.
- As a result, there is in each system a growing interest in leaving people in their homes or identifying other non-residential settings in which to deliver care.
- Despite the growing interest in non-residential alternatives, however, where people go for treatment is more often a function of reimbursement incentives than personal preferences. These reimbursement incentives create implicit biases favoring the use of residential treatment.
- As a result, each system can be divided into two systems, the first of which is highly institutional, receiving the majority of the money but serving only a minority of those in need. The second system tends to be much more community-based, even home-based. It receives little public funding but serves substantial numbers of people. Because of current financing arrangements, these two systems do not compete.
- Despite the growing support for non-residential and community-based alternatives, there is a fear that supporting these opportunities would incur the so-called "woodwork effect" (i.e., that people would come out of the woodwork to receive publicly reimbursed care), which could add costs to the system as alternative forms of care are substituted for residential care opportunities.
- In each system public costs are growing at rates which seem excessive, largely because of the residential, 24-hour nature of care and the substantial staff requirements needed to continue to provide care this way.
- Much of the discussion surrounding controlling these costs has, in nearly every system, centered on the need to control the supply of beds and facilities which are allowed to operate in the system. (And there are legitimate concerns about the size of the treatment capacity, i.e., numbers of beds and facilities, in each system and whether the current mix is appropriate. It is true that we have both too much of some kinds of facilities and too little of others.)

- But it is also true that in each of the systems the reliance on "supply side" controls to contain costs is increasingly being viewed as a short-term, interim solution which would suffice until a long range strategy can be found.

Apart from these issues, there is another subset of similarities which, though not as immediately apparent, may be even more significant in the long term. By and large they deal with the relationships between those who receive service and those who deliver service. It is clear that a silent transformation is occurring here. It has to do with the following questions:

- Will disabled individuals be allowed to become as self-sufficient as possible or will they be encouraged to become overly dependent on professionals?
- Can the interests of caregivers and recipients be presumed to be the same?
- When conflicts arise between persons with disabilities and professional caregivers, whose interests will predominate?
- What is the impact of professional intervention (the formal system of care) on family and other (informal) system networks? Do present systems serve to supplement informal support networks or supplant them?
- Who decides how much care, of what kind is to be rendered, when it is to be proffered and the setting in which it is to be delivered?
- Are such decisions properly the province of the professional, individuals, government or the family?
- What happens to the ability to leverage change, on one's own behalf, when reimbursement is provided by an absentee third party, particularly when a public subsidy is involved?

That such questions are being raised at all is an indication that our attitudes toward social services and service delivery are being redefined in fundamentally new ways. To fully understand and appreciate this discussion it must be viewed in its historical context.

American political thought is laced with conflict over the issue of individual liberty versus "the general welfare" or societal interests. The early colonists defined guarantees of individual rights negatively as the ability to be protected from excessive exercise of governmental power. This view followed from the colonists' view of human nature, since they believed that no one was safe from the temptation to abuse power. If no one could be trusted with power then eternal vigilance must be exercised in order to protect the liberties of the individual.

From this world view, the protection of individual liberty could be nothing less than a continuous adversarial process between the governors and the governed. The interests of both groups were seen as being inherently at odds.

With the advent of the Progressive era, however, that world view changed. Although the Progressives believed that men were inherently self-interested, they also believed in a cure for that malady. The cure was "socialization" --more contact with "culture," greater exposure to religion and above all, further education. Devoted to the doctrine that "the sum of individual self-interested actions could no longer be counted upon to produce the common good, the Progressives relied upon social processes to overcome individual avarice. In particular, they relied upon government to correct various social ills.

The Progressive agenda for government reform was as impressive as the need for reform. Government, it was felt, should intervene in order to assure the right of workers to express their grievances with business. Government should stop the exploitation of labor, particularly child labor. The poor should no longer be blamed for their plight; rather blame should be placed on an unfair economic system. Accordingly, the state should assume some financial responsibility for the poor, the industrially maimed, the widow with little means. As David Rothman, the noted sociologist, has observed, "the major tenet of the Progressives' thought was that only the state could make the individual free," because only the state could satisfy all of its citizens needs.

With such a world view, there could be no conflict between the government and the governed. Their interests were presumed to be the same. What conditions lead the Progressives to that assumption?

The first and undeniably the most significant such condition was the expanding American economy. With an expanding economic pie, the degree of social conflict, though not eliminated, fell considerably.

The other major reason was the need to socialize America's burgeoning immigrant population in order to quickly fit them into the "melting pot" of American business. Once employed, they could continue to contribute to the growth of the economy and the national welfare.

In line with the Progressive philosophy, the concept of government grew from a simple definition of political institutions to embrace the "social institutions of caring" -- public schools, state mental hospitals, public housing authorities, developmental centers for the retarded, foster care agencies for homeless children, nursing homes for the aged and welfare agencies for the poor.

Today the policies of the Progressives are being reevaluated. Ironically, the harshest criticism has come from the perspective of the poor -- the very population with which the Progressive policies professed the most concern. David Rothman, in his essay, "The State as Parent: Social Policy in the Progressive Era," has written:

"The very heart of the current dissatisfactions with Progressivism to its critics (is that) the movement suffered from an absence of moral realism. Its proponents were so attached to a paternalistic model that they never concerned themselves with the potential of their programs to be as coercive as they were liberating. In their eagerness to play parent to the child, they did not pause to ask whether the dependent had to be protected against their own well-meaning interventions."

Ira Glasser, the executive director of the American Civil Liberties Union in New York, holds that the new attitudes of the poor toward publicly provided social services came about during the "welfare rights revolution" of the 1960s and 1970s. In his essay, "Prisoners of Benevolence: Power Versus Liberty In the Welfare State," Glasser has observed that social service providers, believing that their motives were good, "failed utterly to resist the...endlessly propulsive tendency of power to expand itself and establish dominion over people's lives." Glasser noted that:

"We became oblivious, in the context of social services, to the adversarial relationship between power and liberty, and we assumed that the interests of clients were not in conflict with the interests of social service agencies. In fact, we adopted the fiction that the interests of clients were identical with the interests of social service agencies, a fiction we have not completely shed."

Such concerns are considerably sharpened when the discussion turns to the issue of who is responsible for defining "needs." Professor John McKnight of Northwestern University has noted that social service professionals have claimed the license to define what the problem is, what should be done about it, as well as to evaluate whether or not their solutions were effective. "Leadership becomes impossible when the claims of professionals are so comprehensive," McKnight says, because it strips clients of any personal sense of legitimacy or efficacy. The dignity of risk is lost. People become simply "clients" and society is encouraged to view them as social liabilities instead of social assets.

Social service professionals make claims on society's resources in order to meet human needs. Because needs are not an economic term, they cannot be limited. Hence, neither can society's response to these needs be limited. But precisely at this point, McKnight cries "foul". Social service providers because they deliver "service" – have an economic incentive to provide more service than "clients" may want or "need."

According to McKnight:

"Removing the mask of love shows us the face of servicers who need income, and an economic system that needs growth. Within this framework, the client is less a person in need than a person who is needed. In business terms, the client is less the consumer than the raw material for the servicing system. In management terms, the client becomes both the output and the input. His essential function is to meet the needs of servicers,

the servicing system and the national economy. The central political issue becomes the servicers' capacity to manufacture needs in order to expand the economy of the servicing system."

To the extent that these observations are valid, a set of additional concerns emerge for a review of social services practices:

- The creation of need often where actual may not exist.
- Defining need in terms of what service professionals can provide rather than what may actually be required.
- Persuading clients that their perception of their own needs is fallible, that they do not have the training or skill to judge the services they are receiving, and that they cannot rely on their own assessments of whether they are sufficiently served.
- The promotion and use of labels that define clients in terms of their weaknesses and ignore their strengths, thereby encouraging dependent classes to ask only what service providers can do for them rather than what they can do for themselves.

Tom Dewar, Senior Fellow at the Humphrey Institute, has added a haunting postscript to the McKnight thesis. As Dewar states, "In the end ... the relationship between need and service is severed and the issue of equity is turned on its head." A client's right to treatment is ultimately transformed into the professional's right to treat everyone.

These characteristics seem severe, yet they point to a dimension of analysis that cannot be wisely ignored. Minnesota has a strong, proud tradition of progressive social policy., But it has come to make too much use of the institutional option. The time is right for a review of the states policies and practices which deliver assistance to populations with special needs.

COMMITTEE FINDINGS

I. HISTORICALLY, SOCIETY HAS POUND THAT PROVIDING CARE TO VULNERABLE POPULATIONS IS A PERPLEXING PROBLEM FOR WHICH THERE ARE FEW EASY ANSWERS. OUR PRESENT SYSTEMS FOR CARING FOR THE ELDERLY, THE MENTALLY RETARDED, THE MENTALLY ILL, JUVENILE DELINQUENTS AND THE CHEMICALLY DEPENDENT WERE ALL FOUNDED AS A RESPONSE TO UNSATISFACTORY CONDITIONS IN THE PAST.

- A. The evolution of nursing homes provided new alternatives to elderly citizens who were formerly cared for in public hospitals and county poor farms.

As institutions began to specialize, boarding homes for the aged gradually emerged, often under the auspices of religious organizations. These homes began providing nursing services as their residents grew older and their health deteriorated.

A direct result of the Social Security Act of 1935 was that many elderly Americans were guaranteed an income stream which allowed them to pay for nursing home services. Proprietary nursing homes responded to this demand.

In the 1960s enormous public concern was aroused over the adequacy, accessibility and affordability of health care services for the elderly. In response, the federal government created the Medicare and Medicaid programs. However, the availability of virtually unlimited public reimbursement for health and long-term care stimulated substantial increases in the number of nursing home providers.

As the nursing home industry grew, media reports of abuse and neglect of elderly people in nursing homes also increased. In response, the Minnesota Legislature turned increasingly to regulatory measures designed to improve "quality assurance." Today, there are no less than ten components in Minnesota's efforts to monitor the activities in its nursing homes. They include federal certification, state licensure, quality assurance review, the Office of Health Facility Complaints, Fire Marshall inspections, technical consultation and training, utilization control, utilization review, the involvement of the state Attorney General's Office and a Long-Term Care Ombudsman.

In the early 1970's, growing concerns about increasing costs and the growing number of nursing home beds led to the enactment of certificate of need legislation. Certificate of Need was intended to slow down the rate of facility growth by mandating that every facility seeking to open or expand a facility demonstrate that the efforts were not duplicative of other community efforts.

- B. Many mentally retarded persons were also removed from state hospitals as a result of the deinstitutionalization movement.

In the past, the mentally retarded were placed in almshouses, asylums and the public poorhouse. Minnesota's initial efforts to deal with

this population came in 1881 when the Legislature directed that the School for Idiots and Imbeciles be connected with the Institute for the Deaf, Dumb and Blind. In 1887, the school (which later became Faribault State Hospital), was made a department of the Minnesota Institute for Defectives, which, at that time, was the largest state institution in Minnesota.

The first residential facility for mentally retarded people was established in Massachusetts in 1848. Within thirty years, similar institutions, now called state hospitals had been built in most other states. While the initial thrust of these organizations was to treat the retarded and return them to society, by the 1880's, that emphasis had changed to one of protecting mentally retarded people from society. Over time, that philosophy changed as well, to one of protecting society from the retarded. From the 1880's to about 1925 state hospitals fulfilled this latter function.

The number of mentally retarded persons in state hospitals in the United States increased from 2,429 in 1880 to nearly 195,000 in 1967. Then a dramatic reversal began to take place, premised, in part, on the deinstitutionalization movement.

National trends show a continuing downward trend in the number of persons with developmental disabilities residing in large public institutions. At its height in 1967, approximately 194,650 such persons lived in state hospitals. By 1982, that number had declined to about 130,000.

Here in Minnesota, the number of mentally retarded persons living in state hospitals peaked in 1950 with a total population of 6,008. By 1982, that number had fallen to 2,400. As a result of a state legal ruling, the *Welsch* versus *Levine* consent decree, the number of mentally retarded persons residing in state hospitals will number no more than 1,850 on July 1, 1987.

- C. The first wave of reform in the treatment of the mentally ill brought the creation of the asylum, the forerunner of the state hospital. After documented abuses and the evolution of psychotropic drugs, a second wave of reform pushed for deinstitutionalization.

That America adopted an institutional response in its treatment of the mentally ill stemmed from its conception of the origin of this problem. As David Rothman observed in his reknowned study *The Discovery of the Asylum: Social Order and Disorder in the Hew Republic*:

The institution itself held the secrets to the cure of insanity. Incarceration in a specially designed setting, not the medicines that had to be administered or the surgery that might be performed there, would restore health. This strategy for treatment flowed logically and directly from the diagnosis of the causes of the

disease. Medical Superintendents located its roots in the exceptionally open and fluid quality of American society. The American environment had become so particularly treacherous that insanity struck its citizens with terrifying regularity.

One had only to take this dismal analysis one step further to find an antidote. Create a different kind of environment, which methodically corrected the deficiencies of the community, and a cure for insanity was at hand. This, in essence, was the foundation of the asylum solution.

The institution would arrange and administer a disciplined routine that would curb uncontrolled impulses without cruelty or unnecessary punishment. It would re-create fixity and stability to compensate for the irregularities of the society. Thus, it would rehabilitate the casualties of the system. The hospital walls would enclose a new world for the insane, designed in the reverse image of the one they had left. The asylum would also exemplify for the public the correct principles of organization. The new world of the insane would correct within its domain the faults of the community and through the power of example, spark a general reform movement.

Over time however, the Utopian fervor behind the asylum movement was lost. Institutional rehabilitation quickly gave way to socially sanctioned custodianship or incarceration. Asylums gradually came to house criminals, the insane, the mentally retarded, and the poor. With the advent of psychotropic drugs, a professional consensus developed which believed that long-term institutionalization was anti-therapeutic. Documented abuses, coupled with this belief gradually lead to the deinstitutionalization movement.

Deinstitutionalization has been defined as "the process of preventing unnecessary admission to or retention in institutions; developing community alternatives for treatment, rehabilitation, housing and other basic needs; and improving conditions for persons who continue to require institutional care." The underlying principle is that "mentally disabled persons are entitled to live in the least restrictive environment necessary and lead their lives as normally as they can.

As a result of the deinstitutionalization movement, state hospital populations have declined steadily since the mid-1950's. For example:

- Nationally, state hospital populations declined 73/2% from 1955 to 1978, moving from a peak of 559,000 in 1955 to approximately 150,000 in 1978.

- During the same period, Minnesota's state hospital population dropped from 16,000 to about 5,100, a 68.2% decline.
- Minnesota's mentally ill population in state hospitals declined even more dramatically over this time period, (87%) moving from 11,500 in 1955 to 1,500 in 1978.

D. Juvenile courts were created to establish a separate and distinct system of justice for children. The juvenile court was expected to intervene early enough to prevent minor offenses from becoming major ones.

Many early American practices with respect to dependent or delinquent children came from England. Both countries relied heavily on orphanages and the process of allowing children to become indentured servants to individuals and families until they reached the age of majority. In return for their labor, children would receive room and board. Both of these practices were widespread during the 17th and much of the 18th centuries.

Other means of dealing with orphaned, neglected or simply poor children during the 18th century included the public poorhouse or almshouse. These institutions were also used by the mentally ill, the mentally retarded and the elderly.

The 19th century saw the creation of "houses of refuge" for children who had run away, were disobedient or had committed minor crimes. The social movement which created these institutions held that the problems of children could not be attributed to them alone, but must be seen in a broader context of dysfunctional families and social problems. Minnesota's first protective law for children, passed in 1866, embodied this philosophy. Not surprisingly, 1866 also marked the creation of a state training school called a House of Refuge. {This school was transferred to Red Wing in 1899.) In 1885, the State School for Dependent Children was established in Owatonna. It later became the Owatonna State School and was closed in the 1960's.

By the latter part of the 19th century, the progressive era had brought about numerous reforms related to children. Growing public reaction against almshouses and houses of refuge led states to outlaw their use. Child labor laws were enacted to protect underaged children from abuses in the workplace. (Minnesota passed its first child labor law in 1895.)

The creation of the juvenile justice system and juvenile court was an important contribution of the progressive era.

The juvenile court was created for three reasons: to prevent the often harsh treatment of juveniles in the adult corrections system, to assure that young people would no longer be tried in criminal courts and to intervene early enough with juvenile offenders to prevent their further involvement with the law.

In the early days of the nineteenth century, prisons failed to segregate juveniles from hardened adult criminals. Courts held that

children under the age of seven were incapable of criminal intent. Children between the ages of seven to fourteen were usually seen as incapable of criminal intent, but that was subject to continual scrutiny by judge and jury if it was believed that the child could discern "the difference between good and evil." Once children reached the age of 14, they became adults in the eyes of the law.

The idea of a separate court for juveniles originated with a group of Illinois reformers in the 1890's. In 1905, the first juvenile courts were established in Minnesota in Ramsey, Hennepin and St. Louis Counties. By 1909, juvenile courts had been created in every county in Minnesota. H. Ted Rubin, Senior Associate of the Institute for Court Management in Denver, Colorado, and himself: a former juvenile court judge, has explored the early days of the juvenile justice system. According to Rubin:

"The writings of early juvenile judges reflect impressive case individualization, an enormous commitment to helping youths, strong efforts to reform social institutions to be either less oppressive or more assisting to young people, together with a disinterest in legal procedures and safeguards. They reveal the preventive goal of the court: that intervention with a dependent or neglected child would avert what we now call a status offense; that court-ordered supervision of status offense youngsters would eliminate or reduce delinquency; that programs for delinquents would avert their later criminality."

Gustav Schramm, a long-term Pittsburgh judge, described the position of a juvenile court judge as:

"Neither umpire nor arbiter, he is the one person who represents his community as *parens patriae*, who may act with the parents, or, when necessary, even in place of them to bring about behavior more desirable. As a judge in a juvenile court, he does not administer criminal law. The child before him is not a defendant. There is to be no conviction, no sentence. There is to be no life-long stigma of a criminal record. In a juvenile court the judge administers equity; and the child ... is the recipient of consideration, of guidance and correction."

- E. Major reforms in the area of chemical dependency removed public drunkenness from being a civil offense and helped the public understand that alcoholism is an illness. Treatment shifted from the county jail to hospitals.

In 1907 the Minnesota Legislature passed a 2% tax on liquor licenses to build and maintain an institution for chronic alcoholics. Willmar State Hospital was opened in 1912, and over a period of years developed a multi-disciplinary approach to treating alcoholics.

Alcoholics Anonymous (AA) came to Minnesota at the start of the 1940s and expanded rapidly. In those days, it was assumed that an alcoholic must "bottom out" before his/her situation would be sufficiently desperate to turn to a program of sobriety. Experiences at the Willmar State Hospital and other treatment programs however, showed that effective results could be obtained by individuals cajoled into treatment before they bottomed out. Gradually, the process of pressuring prospective patients into treatment came to be accepted as common practice and is referred to today as "early intervention."

By the late 1940s, AA in Minnesota had grown significantly and a Hennepin County group opened the Pioneer House Treatment Program in October 1948. In March 1949, the Hazelden program was initiated by Saint Paul interests.

Private hospital involvement in the treatment of alcoholics began in the mid-1960s. St. Mary's and Northwestern Hospitals in Minneapolis and St. Luke's in Saint Paul began admitting some patients diagnosed as alcoholics. In 1968, St. Mary's Hospital began the first Minnesota primary treatment center located in a private hospital.

Having had favorable experiences with employees treated at Hazelden and other centers, Minnesota corporations began including chemical dependency treatment in their employee health insurance packages. Such coverage expanded voluntarily during the late 1960s and early 1970s. In 1973, the Minnesota Legislature required health insurance plans to cover chemical dependency treatment in hospitals.

All of these developments helped change public perceptions of alcohol abuse and encouraged people to see it as an illness. In 1969 the Minnesota Supreme Court formalized that view, ruling that individuals could no longer be arrested for public drunkenness.

III. TODAY, MINNESOTA IS DEALING WITH A VARIETY OF NEW ISSUES WITH REGARD TO THESE POPULATIONS. MANY OF THESE ISSUES WERE CAUSED, IN PART, BY THE REFORMS OF THE PAST.

- A. Although the poverty rate for the nation's elderly population has declined significantly, the elderly remain financially vulnerable to the high costs of nursing home care. Current financial incentives encourage the transfer of private assets in order to pay for care and so contribute to public costs.

According to Sheldon Danziger, an economist at the University of Wisconsin's Institute for Research on Poverty "the aged are now, on

average, no more likely to be poor than the non-aged." The elderly have benefited greatly from federal cash transfer programs. The poverty rate for persons aged 65 and over was 14.6 percent in 1982 and, for the first time in history, was less than the poverty rate for the nation as a whole. In Minnesota, the poverty rate for the elderly has decreased from 26 percent in 1970 to 15 percent in 1980. In comparison, the 1980 Minnesota poverty rate for the general population was about 8 percent.

The Minnesota State Planning Agency, in a major report entitled Minnesota's Elderly in the 1990's has concluded that "the aggregate economic status of the elderly will improve over the next twenty years." The report based its conclusion on the following trends:

- The maturation of the private and public pension systems and the long-term care effects of pension reforms will increase the proportion of elderly who receive pensions as well as the amounts of their benefits.
- If there are strong incentives for the elderly to work or if the retirement age under Social Security is raised, the income of the young-old will rise because of earnings, and Social Security and pension benefits may be incrementally higher after retirement.
- The elderly of the 1990's will have larger assets because of the absence of a sustained depression during their working years, the substantial appreciation of the homes they own, and the prevalence of two-earner families.
- The continuing increase in labor force participation by women and the prevalence of two-earner families will result in higher Social Security benefits for women who retire in the 1990's, whether married or unmarried.

Despite the upbeat nature of these trends, the high costs of nursing home care leave the elderly and the public vulnerable to catastrophic expenses. Personal assets are often depleted soon after entering a nursing home. Nursing home costs averaged about \$49 a day in Minnesota in 1982 or about \$1,500 per month. When personal assets are gone, government pays for people's care. About two-thirds of Minnesota's nursing home residents received Medicaid in 1982.

In contrast to the financing of hospital costs for the elderly, almost none of their nursing home costs are covered by public or private insurance. Medicare, the primary form of health insurance for the elderly, is geared to acute care. While it does provide for some nursing home care, the coverage is confined to short-term, post-hospital convalescence and the amount expended is extremely limited. In 1980, only one percent of Medicare expenditures went for nursing home care. That amounted to only two percent of total national nursing home expenses (Gibson and Waldo, 1982).

"Medigap" policies are the private insurance industry's contribution to financing health care for the elderly. But such policies generally only cover the co-payments and deductible provisions of Medicare. Only about 1.5 percent of the elderly's nursing home care expenditures were paid by private insurance in 1980 and that was typically limited to short stays requiring intensive skilled care.

A third means of financing nursing home costs is Medicaid. Although the intent behind Medicaid may be to provide a social insurance program, a significant number of people are not covered by it. As Mark Meiners of the National Center for Health Sciences Research has stated, "in addition to those who would not be eligible for Medicaid because their income is too high, there are those who would not view Medicaid as an acceptable alternative because it would only pay a portion of their bills." Meiners has estimated that the number of elderly who would not view Medicaid as an adequate replacement for private coverage (were it available) to range from 500,000 to 1.3 million families and from 2.2 to 40 million couples. In percentage terms, that would amount to 7 to 17 percent of all elderly individuals and 30 to 54 percent of elderly couples.

Private insurers have chosen not to offer long term care insurance for a variety of reasons. The availability of public long-term care programs as a safety net has had a deterrent effect on the potential market. But insurers have remained skittish about entering this area largely due to traditional concerns of adverse selection, insurance induced demand; administrative economies and the perceived difficulty in setting limits in long term care. Moreover, traditional thinking within the health insurance field is that nonmedical services are not insurable. Since long-term care is often defined to include personal and social services such as homemaker care, nutritional services, and respite care, along with medical and rehabilitative care, this is thought to have stymied innovation. As a result, targeting coverage on the basis on the level of care is felt to be arbitrary and open to challenge.

The consequences of the unavailability of long term care insurance have been that the elderly and their families directly financed about 52 percent of nursing home services, the primary component of long-term care (Fisher, 1982). This amounted to an out-of-pocket nursing home expense for the elderly of \$269 per capita, a sum that is nearly twice the \$136 spent per capita out-of-pocket by the elderly on hospital and physician expenses combined. Such spending represents catastrophic costs for many elderly and leads to their impoverishment. This process is made worse still by Medicaid spend-down provisions.

Davidson and Marmor, after reviewing the Medicaid spend-down process, concluded that "the effects of spend-down laws are subtly punitive: an older person does not become eligible for medical assistance until he has been struck by serious illness and has depleted income and assets to the point of total dependency."

There are two ways to qualify for Medicaid. The first is to spend income and assets down to the level necessary to meet the programs income specifications. In Minnesota, a single individual can have \$3,936 net income per year; a family of two can have income of \$4,944 and a family of three an income of \$6,000. Minnesota allows "unlimited equity in the homes in which residents reside" and also excludes income producing property, a car, and personal property assets of up to \$6,000." {DPW Memo, December, 1983}.

The other way to qualify for Medicaid is to transfer one's assets to the point where eligibility is reached. As Mark Meiners of the National Center for Health Services Research has observed, "It is not surprising that people have chosen (this) latter option. It is usually more appealing to pass along one's estate to close relatives than to pay it out gradually to a nursing home when the end result in either case is that the patient will have to go on Medicaid."

Federal and state gift tax laws provide the elderly with even more incentives to transfer their assets to their children. At the federal level people are currently entitled to a one-time tax-exempt gift of up to \$275,000. According to a spokesman for a prominent Minneapolis law firm, that amount will increase to \$600,000 by 1987 under federal law. In addition, people can give a one-time, annual tax-exempt gift (per donee) of up to \$10,000. Thus, for a family with two children existing federal laws would allow them to give a one-time, tax-exempt gift of \$295,000.

Minnesota's gift tax laws are even more lenient. Minnesota has no gift tax any longer, regardless of the size of the gift.

In response to such practices, federal regulations regarding transfer of assets have recently been strengthened to make it more difficult to qualify for SSI (Supplemental Security Income) and Medicaid. Resources disposed of within 24 months of the date of application at below market value for the purpose of establishing eligibility for SSI benefits including Medicaid will be counted in determining eligibility, and the period can be extended if the uncompensated value of the resources exceeds \$12,000. The right to extend these restrictions to cover anyone eligible for Medicaid has recently been given to states along with the right to place liens on the homes of nursing home residents.

The possibility of the state placing liens on the homes of nursing home residents raises the question of whether elderly people's homes should be counted as an asset when determining Medicaid eligibility.

In the past, Minnesota, like many other states had an Old Age Lien Law. This law allowed the state to place a lien on the homes of elderly people in return for financing their care. At death or upon the sale of the home, the state would receive all or some of the proceeds. Over time, as economic conditions improved, opposition to

this practice grew. It was argued that in cases where a person had to sell the family home to finance the cost of nursing home care, the effect of the law was to place not only the person but also their spouse in the nursing home. Farmers objected to the practice on the grounds that it could mean sale of the family farm.

Others have argued though, that the repeal of the Old Age Lien Law has had the effect of subsidizing wealthier state citizens at the expense of the poor, subsidizing the heirs or children of the elderly and indirectly increasing the financial dependence of the elderly on the state, thereby increasing public costs.

- B. Over time, people came to understand that residential treatment of the mentally retarded in "community facilities" may or may not be any less "institutional" than institutional care itself.

Deinstitutionalization is gradually being redefined. The National Association of Superintendents of Public Residential Facilities for the Mentally Retarded (1974) defined deinstitutionalization as a three-fold process:

- 1) prevent admission to public residential facilities by finding and developing alternative community residential facilities;
- 2) return to community residential facilities all public residential facility residents who have been prepared through programs of rehabilitation and training to function in ... local settings;
- 3) establish and maintain responsive residential environments which protect human and civil rights and which contribute to expeditious return of the individual to normal community living whenever possible.

According to this orientation, release from a state hospital to a community facility may or may not complete the process of deinstitutionalization. A community facility may or may not be any less institutional than a state hospital depending upon its program, personnel and environment. The determining factor is the extent to which the environment promotes independence, normalization and reintegration into the community.

The growing emphasis on "normalization" stems from the results of years of research which asserts that "limitations of all retarded people are modifiable regardless of their degree of impairment." (Bruininks, Kudla, Hauber, Hill and Wieck, 1981) That being so, then with education and training retarded persons can eventually be expected to live lives that are similar to the "norms and patterns of mainstream society."

Based on the above definitions, how much progress has Minnesota made in deinstitutionalizing its mentally retarded population and what remains to be done? While the state has been largely successful in

helping people to leave state hospital settings, approximately 2,395 retarded people still live there. Between 5-10% of these residents are children. The table below indicates that despite the recent emphasis on "normalization" and use of the "least restrictive alternative" most mentally retarded persons in placement continue to live in the most restrictive settings.

MENTALLY RETARDED PERSONS IN PLACEMENT, MINNESOTA
(1983)

FACILITY TYPE	POPULATION
STATE HOSPITAL	2,395
NURSING HOMES	300
CONTRACT GROUP HOMES	4,790
FOSTER CARE	600
SEMI-INDEPENDENT SERVICES	500
OWN HOME OR APARTMENT	NC

(SOURCE: Governor's Planning Council on Developmental Disabilities, January 1983).

Critics have argued that Minnesota does comparatively little to keep retarded persons out of residential treatment facilities altogether or at home with their families. Lyle Wray, for example, the court-appointed monitor for the Welsch versus Levine Consent Decree has observed that only 2-3% of the state's budget for hospital and group home placements is directed towards semi-independent living services (SILS) or a family subsidy program to help care for family members at home. By comparison, South Dakota puts approximately 30% of its developmental disabilities budget into a SILS program.

- C. Although deinstitutionalization was an important reform in the care and treatment of the mentally ill, it created some new problems.

Despite the promise of the deinstitutionalization movement, the practical application of this philosophy has been problematic. Some persons with mental illness were deinstitutionalized before alternative community treatment programs could be developed. Other people fell in the cracks of the community system. For many, community care was too fragmented and uncoordinated to reassemble all of the services which had formerly been packaged in the institution.

Often, state hospital patients received little preparation prior to being discharged and afterwards received little follow-up care. As a result, many were soon readmitted to state hospitals. National data show that a large proportion of admissions to state hospitals were readmissions. In 1972, 64% of such admissions were readmissions. About one-half of all persons discharged from state hospitals are readmitted within one year.

Minnesota has not been exempt from this problem. In 1978 the Governor's Mental Health Task Force concluded:

"Judging by the large number of readmissions, {over 50% of state hospital admissions were readmissions) one cannot help but wonder what is happening to these individuals in their own homes after being discharged from state hospitals. The data raise serious questions about the availability and quality of after-care and follow-up services ... and about the screening and treatment available in the community to prevent hospitalization or rehospitalization." (pp. 17-18)

According to a recent survey by the National Institute of Mental Health, state hospital populations are beginning to rise again as more young, chronically ill patients are being admitted. These patients, generally between the ages of 18 and 34, tend to be more aggressive and prone to drug abuse than previous patients, and account for 42 percent of new admissions to state mental hospitals. Anoka State Hospital has reported that 80 percent of its' admissions in the last three years are young-chronic patients.

D. There is growing dissatisfaction with the state's juvenile justice system.

Beginning in the late 1960s and early 1970s, the United States began to re-think its policies relating to the juvenile court. The U.S. Supreme Court found "significant failures" in the juvenile court's ability to achieve its original benevolent purposes. In *In re Gault*, the Court stated, "there is evidence ... that may be grounds for concern that the child receives the worst of all possible worlds: that he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children."¹¹

Much of this policy reformulation centered on the large numbers of young people who were placed outside their homes on the basis of status offenses. Status offenses are delinquent acts committed by juveniles which would not be crimes for adults. They include truancy, alcohol use, running away and "general incorrigibility." During the 1960s and 1970s, virtually one-half of all juveniles in correctional facilities were status offenders.

Following hearings in the U.S. Senate in 1974, Congress passed the Juvenile Justice and Delinquency Prevention Act of 1974. This Act had three major goals. First, it sought to refocus the efforts of the juvenile justice system on the most serious offenders and those considered a danger to society. Secondly, the Act sought to encourage the removal of status offenders from correctional facilities. (New evidence found that such facilities tended to encourage rather than discourage criminal behavior.) Finally, the Act sought to apply the same kinds of civil liberties enjoyed by adults in criminal court to the juvenile court system.

While many states removed status offenses from the justice system, and some from the jurisdiction of the juvenile court, the hoped for reforms intended by the Juvenile Justice Act of 1974 never materialized. From 1974 to 1979, the juvenile institutionalization rate declined by only 15 percent. This seemed especially surprising since both the national juvenile population and the incidence of serious juvenile crime had been declining.

In Minnesota concerns about the state's juvenile justice system have been raised by Ira Schwartz of the Humphrey Institute, the Minnesota Criminal Justice Program, the Urban Coalition of Minneapolis, the Minnesota Citizens Council on Crime and Justice and the Minneapolis Star and Tribune. A report prepared for the Minnesota State Legislature by Kerry Fine of the House Research staff produced troubling findings and lead to the creation of the Minnesota Commission for the Recodification of Juvenile Statutes. Finally, the Minnesota Supreme Court Juvenile Justice Study Commission, in its 1982 report, "Changing Boundaries of the Juvenile Court: Policy and Practice in Minnesota" produced two major recommendations for change. First, the Commission recommended that all status offenders be removed from the court's delinquency jurisdiction and handled under separate jurisdictional categories. Secondly, the Commission recommended the "testing and development of a statewide alternative to the juvenile court process."

The concerns which have been raised by these groups tend to fall under the following categories:

- 1) There is concern about the extent and effectiveness of out-of-home placement.

Research by Ira Schwartz has demonstrated that there seems to be little relationship between the rate of serious juvenile crime and admissions to juvenile detention centers and training schools. In the early 1970s, when Minnesota's rate of serious juvenile crime declined, admissions to detention centers rose. Later, when the juvenile crime rate began to increase, admissions declined. A report prepared for the Minnesota Legislature found that in 1981 approximately 24,021 children were placed outside their homes. (About one-half of these placements were court-ordered while one-half were "voluntary".) Of those, 15,751 were placed in residential facilities of various types and 8,270 were placed in family foster homes. 169 children were placed outside the state of Minnesota.

- 2) There is concern about the effectiveness of juvenile court intervention.

Several studies cast doubt on the effectiveness of juvenile court intervention. Studies indicate that arrest policies appear to have no effect on juvenile crime or changing behavior. Juveniles

given minimal attention (taken to the station, filing a report, given a warning) showed about the same behavior as those actually taken into the system and given probation.

Over the past twenty-five years Marvin Wolfgang has conducted two major studies of large groups of boys born in the same year in order to trace the number of delinquent acts from birth to age 18. His first study traced the lives of nearly 10,000 boys born in Philadelphia in 1945. A later study tracked 14,000 boys born in 1958. In both groups nearly 65 percent of the boys never had a police record. The prevalence of delinquency in the two groups was quite similar. (35 percent in the first group, 34 percent in the second.) Wolfgang found that most boys with an arrest record committed minor crimes and then stopped. Forty-seven percent stopped after the first offense, 38 percent after the second, and 29 percent after the third. A final group of hard core juveniles with five or more recorded offenses appeared to be chronic offenders and tended to commit more serious crimes (murder, rape, robbery, burglary). But this group was very small – only 6 to 7 percent in either study.

- 3) There is concern about whether juveniles are receiving due process.

In 1967, the U.S. Supreme Court ruled that juveniles are entitled to legal counsel. But in practice, as Gary Crippen, a Worthington district court judge has observed, that right is often "waived" – even in cases where the juveniles are removed from their homes." Research has consistently shown that, particularly for younger offenders, children do not understand the consequences of waiving this right. A full 60% of the children appearing in Minnesota's juvenile courts for both delinquency and status offense charges have no counsel. Even where counsel is present, Crippen says, "they are not always competent in juvenile work or even interested in it."

- 4) There is concern about the broad powers of the juvenile court judge.

Upon the creation of the juvenile court, judges were given broad powers and much discretion. Such powers, it was argued were needed to allow the judge to take an individualistic approach with each child that he faced.

However, recent evidence suggests that the extent of such discretion can lead to a lack of common standards and "justice by geography." A recent study by the Minnesota House Research Department found that "the likelihood of placement depends upon where a youth commits an offense." The report found that "the metro area courts place significantly more children out-of-home" than out state communities. Even within the metropolitan area significant differences emerged. In 1981, Hennepin County placed

58% of its juvenile court cases out-of-home as compared to Ramsey County's 35 percent. Other counties rate of placement was far lower. Wright County's out-of-home placement rate was 10 percent. Pipestone County's was 8 percent and Mower County's was 4 percent.

5) There is concern about the structure of the juvenile court.

The juvenile court is in the unusual position of having one foot in the judicial branch and the other in the executive by virtue of administering the intake, probation and detention services and, in some cases, training schools. There is growing controversy over this dual role. Luke Quinn, himself a juvenile judge in Flint, Michigan, argues that these two functions should be split, that it is a conflict of interest for someone to be both "judge and jailor." David Gilman, the Director of the IJA-ABA Juvenile Justice Standards Project has questioned:

"whether a judge charged with the legal responsibility to administer social service programs can also fulfill his primary obligation to be an impartial trier of facts. The possibility of conflict of interest becomes evident when a judge is required to decide whether a detention decision was properly made, the conditions in a detention facility are violative of constitutional rights, or probation or intake policies are legal, while retaining responsibility for the administration of these same programs or facilities."

E. Important reforms in chemical dependency treatment helped to alleviate under-treatment. Today, however, there is concern that chemical dependency may be over-treated.

The Citizens League, in a 1980 report entitled Next Steps In the Evolution of Chemical Dependency Care in Minnesota found that primary treatment programs operating within the Twin Cities had a treatment capacity of 26,000 patients per year. (14,000 on an in-patient basis and 12,000 on an out-patient basis.) Data developed from responses to a League questionnaire sent to primary treatment facilities showed that in the preceding 12-month period, nearly 20,000 persons were actually served. Of that total, 73% were metropolitan area residents while 14.2% came from out state Minnesota and 12.8% came from other states.

Based on these data, the League study concluded that "numerous factors suggest the possibility of an oversupply of treatment facilities relative to need." Data from the Metropolitan Health Board tend to collaborate that conclusion. Throughout the 1970's in-patient hospital utilization rates declined significantly. Medical and surgical hospital use rates fell from 902 days per 1,000 in 1970 to 774 in 1980. Pediatric hospital use rates fell from 108 to 65 days per 1,000 during this same period. Obstetric in-patient use

declined from 87 to 69 days per 1,000 during this ten year span. By contrast, however, in-patient chemical dependency days per thousand increased from 57 to 73 days per thousand from 1975 to 1980.

Psychiatric days per thousand also increased, moving from 103 days per thousand in 1970 to 127 in 1980. These trends lead some health policy analysts to wonder whether hospitals were using these services to fill empty hospital beds. The new federal system of hospital reimbursement {which pays hospitals on the basis of diagnostically related groups or DRG's) does not, as yet include either in-patient stays for chemical dependency, alcohol abuse or mental illness. As a result, hospitals have incentives (no longer operative under services covered by DRG's), to keep such patients in the hospital for a longer period of time.

The last two years have seen a decline in in-patient treatment of chemical dependency and mental illness. Admissions to hospitals in the seven-county area have declined since 1980 for both of these illnesses. Between 1980-82, chemical dependency admissions declined nearly 14 percent and psychiatric admissions nearly 4 percent.

But these trends tend to mask pertinent issues with respect to the psychiatric and chemical dependency treatment provided to juveniles. For example, while the average time in these programs has declined slightly for juveniles, they tend to be held in such facilities twice as long as adults according to Marilyn Jackson-Beeck, a former official with Minnesota Blue Cross/Blue Shield. Recent data indicate that:

- Juvenile admissions to psychiatric units in Twin Cities area hospitals increased 63 percent from 1976-81 according to the Metropolitan Health Board. (This, despite a 6.5 percent decrease in the area's youth population). In 1976, 1,123 juveniles were admitted to in-patient psychiatric programs accounting for a full 46,718 days of care. By 1983, the number of admissions and patient days increased to 2,031 and 76,899. From 1976-83 the juvenile psychiatric admission rate per 100,000 doubled.

JUVENILE PSYCHIATRIC ADMISSIONS AND PATIENT DAYS IN
MINNEAPOLIS/ST. PAUL METROPOLITAN AREA HOSPITALS

JUVENILE PSYCHIATRIC ADMISSIONS			PATIENT DAYS
Year	Number	Rate/100,000	Number
1976	1,123	91	46,718
1977	1,062	88	53,730
1978	1,268	107	60,660
1979	1,623	142	68,949
1980	1,775	158	74,201
1981	1,745	159	72,381
1982	1,813	165	71,267
1983	2,031	184	76,899

SOURCE: "Minnesota's Hidden Juvenile Control System: In-patient Psychiatric and Chemical Dependency Treatment," Schwartz, Jackson-Beeck, Anderson 1984

- The average length of stay for psychiatric inpatient treatment of juveniles tends to be nearly twice as long as for adults. In 1982 the average length of stay for juveniles was 38.3 days compared to 21 days for adults.
- Juvenile admissions into hospital chemical dependency programs have also increased. Data from Blue Cross and Blue Shield of Minnesota shows that the proportion of chemical dependency in-patients who were juveniles increased from 17% in 1978 to 23% in 1982. From 1978-82, Blue Cross Blue Shield's total costs for in-patient juvenile chemical dependency increased 72%.
- The Juvenile Effective Care '81 Evaluation Program conducted by Minnesota Blue Cross and Blue Shield assessed whether any juvenile chemical dependency or psychiatric treatment was medically unnecessary. Independent reviewers disallowed 12 percent of insurance claims for juveniles in hospital and non-hospital treatment centers for chemical dependency and psychiatric treatment throughout the state for a two year period ending in July 1983.

Trends such as these have led Ira Schwartz of the Hubert H. Humphrey Institute of Public Affairs to question whether the private health care system is substituting for the public juvenile justice system in some of these cases. To Schwartz, such data indicate the presence of a "hidden juvenile justice system."

But David Aquilina, vice-president of the metro area's Council of Community Hospitals, disputes the idea that hospitals are using these services to drum up business. In a Minneapolis Star and Tribune article dated February 19, 1984, Aquilina was quoted as saying that hospitals don't "manufacture the demand for chemical dependency services." Instead, demand results from a "mixture of legally required insurance coverage and the actions of the courts, schools, parents and others who refer people in for treatment. Hospitals don't label kids chemically dependent," Aquilina stated, "parents, doctors, social workers, schools and the courts pin the label on kids and refer them for treatment."

III. WHILE EACH OF THESE SYSTEMS IS STRUGGLING WITH DIFFERENT ISSUES, THE ISSUE WHICH THEY ALL HAVE IN COMMON IS THEIR HEAVY USE OF RESIDENTIAL TREATMENT.

- A. Minnesota makes more use of residential placement in the care and treatment of the elderly, the mentally retarded, the mentally ill, portions of its juvenile population and the chemically dependent than most other states.
 - 1) The Elderly- Minnesota utilizes nursing homes much more intensively than the rest of the nation. Approximately 9.2 percent of the states' elderly live in nursing homes as opposed to the na-

tional average of about 5 percent. Interestingly, this is in spite of the fact that elderly Minnesotans tend to be healthier than their national counterparts and live longer.

Minnesota and the Metropolitan Area are among the top six areas in the country in terms of beds per 1,000 population age 65 and over. Not surprisingly then, Minnesota's rate of nursing home beds per 1,000 population (97.7) vastly exceeds the national average (61.3).

(It should be noted however, that the sophistication of Minnesota's long-term care system makes approximate interstate comparisons difficult. Minnesota has both skilled and intermediate nursing care services, as well as certified boarding care services. Not all states have this mix of services. Instead, they offer other residential services which are not certified. As a result, these non-certified beds may be under-reported in national statistics, artificially inflating comparisons of Minnesota with the rest of the nation).

According to Cindy Polich, a local health care consultant, research shows that age is the primary determinant of need for nursing home care. Yet Minnesota is increasing its rate of nursing home utilization faster than the increase in the elderly population as a whole. An important contributing factor to the growth of the states' nursing home population has been the increasing numbers of Medicaid recipients who are served there. According to a report by the State Planning Agency, the number of Medicaid recipients in nursing homes increased from 27,687 in 1976 to 30,242 in 1979. The report stated that "this growth is much greater than one would expect given population increases during this period." In FY 1979, Minnesota ranked first nationally in the number of Medicaid reimbursed days of nursing home care (skilled and intermediate) per 1,000 persons age 65 and over. (See table below).

STATE	MEDICAID REIMBURSED DAYS OF NURSING HOME CARE PER 1,000 PERSONS AGED 65+
1) Minnesota	22,045.7
2) Georgia	18,986.7
3) Arkansas	18,927.6
4) Louisiana	18,816.7
5) Texas	18,380.2
6) South Dakota	17,928.9
7) Connecticut	17,515.3
8) Iowa	16,255.7
9) North Dakota	14,988.5
10) Montana	14,882.1

(SOURCE: Covered Days, Unpublished Medicaid Data FY 1979)

- 2) Mentally Retarded- According to the 1982 National Census of Residential Facilities: Summary Report (Bruininks, Scheerenberger et. al.) Minnesota ranked third nationally in the number of placements of mentally retarded people per 100,000 population. (See table below).

STATE	MENTALLY RETARDED PEOPLE IN RESIDENTIAL CARE PER 100,000
STATE	MENTALLY RETARDED PEOPLE IN RESIDENTIAL CARE PER 100,000
1) North Dakota	184.18
2) South Dakota	175.84
3) Minnesota	171.04
4) Iowa	156.32
5) Vermont	154.65
6) Connecticut	144.4
7) New York	143.36
8) Pennsylvania	131.20
9) Maine	129.2
10) Missouri	126.26

(SOURCE: 1982 National Census of Residential Facilities: Summary Report)

According to the 1982 National Census of Residential Facilities, Minnesota's rate of placement per 100,000 population (171.04) was significantly higher than the national average (104.65). Minnesota also had many more licensed beds (7,450) in its supervised living facilities for the mentally retarded (not counting independent apartments or nursing home beds) than the national average (6,084).

Prior to the 1982 study, the first census of residential facilities (conducted in 1977-78) had shown that Minnesota ranked first nationally in its placement rate of mentally retarded persons in community residential facilities per 100,000 population. Nebraska, Maine, Montana and Missouri respectively followed Minnesota in the national rankings.

As Lyle Wray has observed, these data may be interpreted in one of two ways. Either Minnesota makes more of an effort to treat the otherwise untreated in residential settings or the state does very little to promote care of the retarded in their own homes. Brad Hill, a University of Minnesota researcher who worked on the 1982 Census believes that the state's number three ranking is a negative reflection on the states' treatment system for mental retardation. It reflects, he says, the states' past over-reliance on intermediate care facilities for the mentally retarded (ICF-MR's) and under-reliance on less institutional settings such as foster care and semi-independent living services.

Comparisons between the 1977 National Census and the updated 1982 version lend further credence to Hills' point of view. Between 1977 and 1982 the overall national out of home placement rate for

the mentally retarded (for all facilities) fell from 114.5 per 100,000 to 104.65 per 100,000. In Minnesota however, during this same time period, the out-of-home placement rate actually rose, moving from 155.5 per 100,000 in 1977 to 171 in 1982. Moreover, when the rate of placement per 100,000 in private facilities with 16 or more residents is isolated, Minnesota ranked first in the nation in 1982 with a placement rate of 112.6 per 100,000 – double the national average of 55.7. The significance of these latter figures is that they tend to highlight the state's over-reliance on large, private ICF-MR's – to the exclusion of other, more homelike care settings.

- 3) The Mentally Ill - In 1979, Minnesota ranked 19th nationally in terms of the number of patients in state and county hospitals. Interestingly, Minnesota ranked 8th nationally in 1977 (the most recent year for which such figures are available) in terms of psychiatric discharges from general hospital in-patient units. Minnesota ranked 15th nationally in 1977 in out-patient visits.

As is the case with the mentally retarded, the majority of Minnesota's mentally ill population which receives formal services receives them in the most restrictive facilities. According to figures provided by Terry Sarazin, Director of State Programs for the Mentally Ill, approximately 22,000 or 6 percent of the states' mentally ill population live in residential facilities. The largest group in residential care according to Sarazin is comprised of about 15,000 mentally ill persons living in nursing homes. Estimates of the number of mentally ill living in various kinds of treatment facilities is listed below:

<u>FACILITY TYPE</u>	<u>NUMBER OF RESIDENTS</u>
Nursing Homes	15,000*
State Hospitals	1,300
Psychiatric Hospitals**	1,100
Rule 36 Facilities***	2,400
Adult Foster Care	750
Other (VA Hospitals etc.)	1,450
TOTAL	22,000

(SOURCE: Minnesota Department of Public Welfare July, 1982)

* 81% of these residents are over age 65

** includes psychiatric units in general hospitals

*** includes board and care and board and lodging facilities

According to Sarazin, an additional 80,000 persons are treated for mental illness on an out-patient basis by counties and public mental health centers.

- 4) Juveniles- According to the analysis of the Children in Custody Series of the U.S. Census Bureau (1982) by the Humphrey Institute of Public Affairs, Minnesota ranked 11th nationally in 1982 in juvenile commitments to training schools per 100,000. Not surprisingly then, the Census Bureau's study also found that Minnesota ranked fairly high in annual per youth expenditures in FY 1982. Minnesota ranked 10th nationally in per youth detention expenditures, spending an average of \$35,594 per youth compared to the national average of \$23,482. The state ranked 11th in annual per youth training school expenditures in FY 1982, spending \$29,312 compared to the national average of \$22,534.

A recent study by the Minnesota House of Representatives Research Department (February, 1983) indicated that "a large number of children" - approximately two and one-half percent of the juvenile population in Minnesota were involved in out-of-home placements in FY 1982. Ninety other juveniles were placed in residential facilities out-side of Minnesota.

Approximately 17,118 juveniles appeared before Minnesota's Juvenile Courts in 1981. (See table below). A full 25% of these young people were placed outside their homes.

JUVENILES IN COURT IN MINNESOTA - 1981								
Total Number of Juveniles	Rate Per 1,000 Juveniles in Population	% Cases Dependency/ Neglect	% Cases Termination Parental Rights	% Cases Person Offenses	% Cases Property Offenses	% Cases Public Order Offenses	% Cases Status Offenses	% Juveniles Placed Out of Home
17,118	15	12%	5%	6%	43%	15%	19%	25%

SOURCE: MN House of Representatives; Kerry Fine, Research Department, 1983

Each of the various types of juvenile cases is briefly described below, along with the dispositions for that type of case.

- Dependency/Neglect and Termination of Parental Rights Cases. Although most cases which go to juvenile court are related to delinquency, about 1/5 are concerned with dependency/neglect or the termination of parental rights. Dependency/neglect cases involve parents or guardians unable or unwilling to provide care to their children. Termination of Parental Rights cases involve either a voluntary or a court-ordered end to the parent-child relationship. In 1981, there were two and one-half times as many dependency/neglect cases as cases involving terminations of parental rights. Approximately 1,695 of the 2,829 children involved in these cases (60%) were placed outside of their homes for reasons of the child's welfare in 1981.

- Delinquency Cases- cover four different kinds of offenses:

- * Person- includes offenses such as homicide, kidnapping, sexual assault, robbery, assault, endangering life, drug sales/manufacturing, DWI and other. In 1981, these offenses made up the smallest number of juvenile cases - about 6-7 percent.
- * Property- includes offenses such as arson, burglary, larceny, auto theft, forgery, fraud, stolen property, damage to property. This category of offenses accounts for the majority of juvenile delinquency cases (53.3%).
- * Public Order- includes offenses such as drug possession, sex offenses, obstruction of justice weapons, disorderly conduct, traffic violations, conservation violations and probation violations. These offenses account for 16.6% of all juvenile offenses.
- * Status Offenses- include liquor violations, curfew violations, running away, incorrigibility truancy, and trespassing. Status offenses represent 25.5% of all juvenile offenses.

Characteristics of Minnesota children involved in delinquency/status offense cases indicate that males account for 78 percent of all cases. Blacks and native Americans tend to be over-represented. Most juveniles in court are in their later teens. Probation was the single largest disposition (46%) in 1981. Approximately 21% of all delinquent/status offenders were placed outside their homes in 1981. According to the House Research report, "this is a large number considering that most offenses are not particularly serious, certainly not violent." "What is perhaps most interesting," the report said, "is that a significant number of minor offenses still result in placement, often in a correctional setting."

- 5) Chemical Dependency- While Minnesotans appear to drink moderately and the incidence of alcohol-related problems is very small, the size of the state's treatment capacity for these problems appears exceedingly large.

In per capita alcohol consumption, Minnesota ranks twenty-fifth among the states. The state ranks even lower in its incidence of alcohol-related problems. According to a 1983 study by the National Institute on Alcohol Abuse and Alcoholism, Minnesota has the sixth lowest rate of alcohol-related problems in the nation. The study used a complex statistical analysis of various problems that are frequently related to alcohol abuse. They range from highway fatalities, murder and suicide to cirrhosis and other medical problems.

Local studies indicate that 6.6 percent of Minnesota residents can be identified as having substance abuse problems. This is consistent with national figures developed for the National Institute on Alcohol Abuse and Alcoholism (NIAA). Applying the national rate to the Twin Cities metropolitan area would produce a figure of approximately 120,000 affected people, while the 6.6 percent estimate would suggest approximately 130,000 people.

Remembering that the Twin Cities treatment capacity alone could serve 26,000 people a year, that means that the treatment system could serve the entire substance abuse population in one four to five year period.

The same distinction between capacity and use can be seen in the following tables. The first table shows Minnesota's utilization rate of various types of treatment facilities. While the state's utilization rate is usually high, its rankings place it in about the middle of the states. The next table, however, clearly shows that Minnesota has a significantly larger treatment capacity than other states,

UTILIZATION OF ALCOHOLISM TREATMENT CAPACITIES BY TYPE OF FACILITY (AS OF
SEPTEMBER, 30, 1980)

FACILITY TYPE	UTILIZATION RATE*	NAT. RANK
Hospital	85	17
Quarterway House	100	2
Halfway House/Recovery	84	24
Other Residential	77	19
Out-patient Facility	86	25
Correctional Facility	64	24
Total	84	25

(SOURCE: NDATUS, 1980)

* Utilization rates are calculated by dividing the actual number of clients reported in treatment by the total capacity reported.

ALCOHOL TREATMENT CAPACITIES BY TYPE OF FACILITY (AS OF
SEPTEMBER 30, 1980)

FACILITY TYPE	CAPACITY	NAT. RANK
Hospital	1,791	6
Quarterway House	7	22
Halfway House/Recovery Home	753	7
Other Residential Facility	922	6

(SOURCE: NDATUS, 1980)

When adjusted on a per capita basis, Minnesota's in-patient treatment capacity becomes even more apparent. According to the Metropolitan Health Board's 1982 Health Systems Plan, "Minnesota has 3 percent of the nation's population and 15 percent of its chemical dependency beds. It has the highest per capita number of hospital-based treatment beds in the U.S., four times higher than New York, Wisconsin, Illinois, Massachusetts and Missouri."

B. The explanation for Minnesota's high rate of institutionalization varies from system to system.

- 1) The Elderly- Four major factors contribute to the high use of nursing homes in Minnesota. They are:
 - Our Scandinavian heritage appears to be a factor. Researchers at the University of Minnesota contend that people of Scandinavian descent pride themselves on their independence from their families and reliance on "social" institutions such as nursing homes.
 - Minnesota has a higher proportion of elderly people than the rest of the U.S. According to the 1980 Census, the elderly comprised 11.4 percent of the U.S. total population. In Minnesota, however, the elderly comprised 12 percent of the total population in 1970. Moreover, while Minnesota has experienced a historical out-migration of its elderly population, (a net total of 14,300 elderly left the state between 1960 and 1970) this trend reversed itself in the early 1970's. Between 1970 and 1977, the state saw a net immigration of 5,250 elderly people.
 - Minnesota's elderly tend to live longer than the national average, thereby increasing their likelihood of needing nursing home care. Minnesota has the lowest mortality rate (15 percent lower) and the highest life expectancy rate of any state in the continental U.S. Among the 50 states, our life expectancy rate is second only to Hawaii. According to a December 1983 report by the Minnesota State Demographers Office, the 38 percent growth in the state's nursing home population during the 1970's "does not reflect an increasing tendency to institutionalize the elderly." Rather, "it reflects the fact that more people are living to an extremely old age." According to the report, 7.2 percent of Minnesota's elderly population (65+) lived in nursing homes in 1970 compared with 8.4 percent in 1980. The majority of the increase was attributed to an increase in residents aged 85 and older during this period.
 - The lack of available alternatives to nursing homes seems to be a contributing factor. A study conducted for the Minnesota Department of Public Welfare (Cost Containment Study: Home Care, 1978) indicates that an insufficient supply of home care ser-

vices exists in Minnesota. This situation results from insufficient funding of alternatives relative to nursing homes and various program restrictions,

- 2) The Mentally Retarded- There are several factors which contribute to the intensive utilization of residential treatment for the mentally retarded in Minnesota. They include the following:
 - DPW has not effectively limited new admissions to state hospitals. This conclusion was reached in a report by the Office of the Legislative Auditor (February 11, 1983). The report stated that "the department has paid little attention to screening new admittees and developing alternative community services that would help to avoid institutionalization."
 - There has been too much reliance on ICF-MR's - to the exclusion of other alternatives. The locus of residential care for the retarded has shifted from state hospitals to community homes, known as Intermediate Care Facilities for the Mentally Retarded or ICFs-MR. National surveys have identified Minnesota as the highest state user of community ICF-MR services. In 1977, there were 170 community facilities in Minnesota. By the end of 1982 there were 311 facilities. The consequences of this dependence on ICF-MR facilities has been that the progress of a number of more able retarded persons toward independent living has been impeded.
 - The manner in which public programs for the mentally retarded are funded contain profound fiscal disincentives to move people from state hospitals to community group homes and from community group homes to less intensive non-residential settings. A June 1983 report entitled Fiscal Disincentives in the Service System for People with Developmental Disabilities by Thomas Chapel of the Metropolitan Council staff has documented these problems in great detail.
 - There is little public funding of in-home care. In Minnesota, the Family Subsidy Program and the Respite Care Program are the only public efforts to help families care for their relatives at home. Neither have been adequately funded and consumer demand often exceeds available supply.
- 3) The Mentally Ill - Funding incentives are also the major reason for the high utilization of residential treatment facilities in the care of the mentally ill.
 - According to a report by the Legislative Auditor, (February 23, 1981) funding issues affect the mental health system in the following ways:
 - * Although there is a multitude of public funding sources available to needy persons, there are numerous restrictions governing eligibility and services covered which limit their use for mentally ill persons in residential facilities.

- * State funds for mental health programming in non-medical community-based facilities have been limited and experimental in nature.
 - * Current funding incentives create incentives for counties to place mentally ill persons in state hospitals rather than in less institutional settings.
- 4) Juveniles- A variety of reasons have been used to account for Minnesota's high rate of juvenile out-of-home placements.
- The Juvenile Court's goal of "rehabilitation" has tended to increase the likelihood of intervention and treatment outside the home. H. Ted Rubin, himself a former juvenile court judge has observed:
- "... we should move away from the past's heavy reliance on the medical model and on attempts at junior psychiatry. This is not to deny that some youngsters are "sick". Rather, it is to state that assisting relationships need not get bogged down in efforts aimed at helping a child understand his unconscious conflicts... A therapeutic purpose opens the detention door more widely, supports longer stays in detention and tends to coerce a treatment model on the general non-adjudicated population."
- A recent report by the Minnesota Citizens Council on Crime and Justice (Out-of-Home Placements of Juveniles: A System in Need of Greater Accountability, October, 1983) came to much the same conclusion. "Diagnostic typologies," they wrote, "were more a function of who was paying for services than an indication of exactness in determining need and placement purpose." The purposes of juvenile placements were also unclear, the Citizens Council concluded and it is difficult to tell "whether the children who end up in one placement are actually behavior ally different from one another." "Often the treatment does not vary sufficiently to justify the many diagnostic labels applied to children."
- The availability of private insurance for chemical dependency and mental health offers some juveniles, their parents and the courts an option that seems preferable to the stigma of the law. Being in treatment therefore is seen as an alternative to being in trouble.
 - Because of the different legal standards which apply to the juvenile justice system, as distinct from the adult legal system, police officers may have an incentive to arrest juveniles in order to be seen as "doing something about crime."

- Some parents and school administrators may view the court system as offering them a respite from the acting out behavior of some adolescents.
- Informed analysis suggests that deficiencies in Minnesota's Juvenile Justice laws sanctions the unnecessary removal of juveniles from their homes.

Harry F. Swanger, the executive director of the National Juvenile Law Center, completed a Review and Analysis of the Minnesota Juvenile Court Act and Related Laws and Rules in August 1982. Swangers' review took the form of comparing state laws to recently approved ABABA standards. Swanger's analysis showed that although Minnesota's approach to juvenile justice was progressive and even avante garde in 1959, when the state's Juvenile Court Act was enacted, it now contains "glaring deficiencies" which argue for a "complete rewrite of the Code. "Exemplary problems with the current Juvenile Code which could exacerbate out of home placement or detention include the following:

- * Minnesota statutes do not require that the least restrictive alternative be used during disposition or in detention decisions.
- * Minnesota statutes permit taking juveniles into custody and detaining the youth in a secure detention facility for up to 24 hours without a court order.
- * Probable cause that an offense has been committed is not required for detention.
- * Juveniles alleged to be delinquents can be detained in a jail or lockup used for adults for up to 8 days if they are placed separate from adults and there is no suitable alternative available for juveniles. (IJA/ABA standards absolutely prohibit jail confinement, as does the federal Juvenile Justice and Delinquency Prevention Act.)
- * The Minnesota statute does not limit the time sanctions or number of dispositions that may be imposed on a juvenile nor does it limit detention that results from adjudication as a delinquent.
- * Status offenses such as "habitual truant" are defined neither by state statute nor by statewide administrative policy, leaving the definition to the discretion of individual schools and courts. (As a result, statewide practices vary greatly - juveniles have been petitioned into court as truants for missing as few as three and as many as 89 school days.)

Swanger concluded his analysis by stating that:

"In the area of dispositions the Minnesota Juvenile Act has by amendment improved the options available to a juvenile court. However, by not mandating a least restrictive approach, including a specified hierarchy of least restrictive to most restrictive dispositions, and leaving open all options in every case, the possibilities of excessive institutionalization and intervention have increased."

- 5) The Chemically Dependent- The way in which chemical dependency treatment is funded is largely responsible for the highly residential nature of the delivery system.

- According to a report prepared for the Minnesota Department of Public Welfare by Cynthia Polich, (An Evaluation of Funding for Chemical Dependency Treatment in Minnesota, December, 1982):

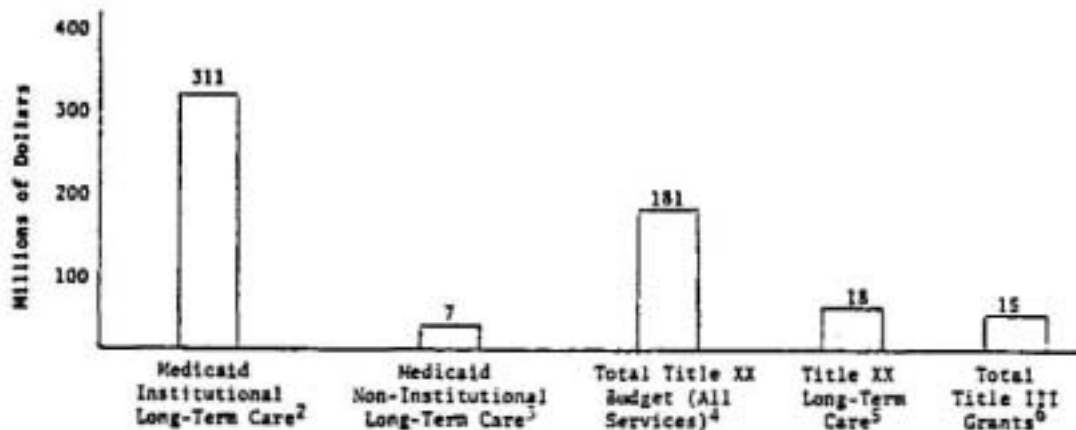
"There is little doubt that the current system of funding for chemical dependency treatment creates biases toward certain types of services or modes of care. The system of funding for chemical dependency treatment does in large part determine the type of treatment that is provided to clients. In addition, the type of treatment encouraged is often the most expensive and intensive treatment available. Modes of treatment are often chosen not because of their appropriateness, but because they are the only modes of treatment that will be reimbursed."

- C. Although people may be institutionalized for a variety of different reasons, the central reason, in each system appears to be that public and private reimbursement is skewed towards the delivery of care in institutional settings.

- 1) The Elderly- Although only 9-10 percent of the elderly live in nursing homes in Minnesota, they receive 90 percent of all public funding for the elderly. While 55 percent of the total state Medicaid budget is spent on institutional care only one percent is spent on community-based long term care services. The major source of funding for community-based care is Title XX. The following table exhibits the total amount of money available for all community services for all age groups through Title XX; this is less than two-thirds of the amount spent for nursing home care only through Medicaid. The other main source of funds for community based long term care is Title III of the Older Americans Act. The total budget for all services through Title III is only about one-twentieth the size of the Medicaid long term care budget.

TABLE XIV

Comparison of Public Funding Sources for
Long-Term Care Services in Minnesota,
All Age Groups,¹ F.Y. 1980



Sources: MDPH, 1981S unpublished data and Title XX Plan, 1980; Minnesota Board on Aging Annual Report 1980 and unpublished data.

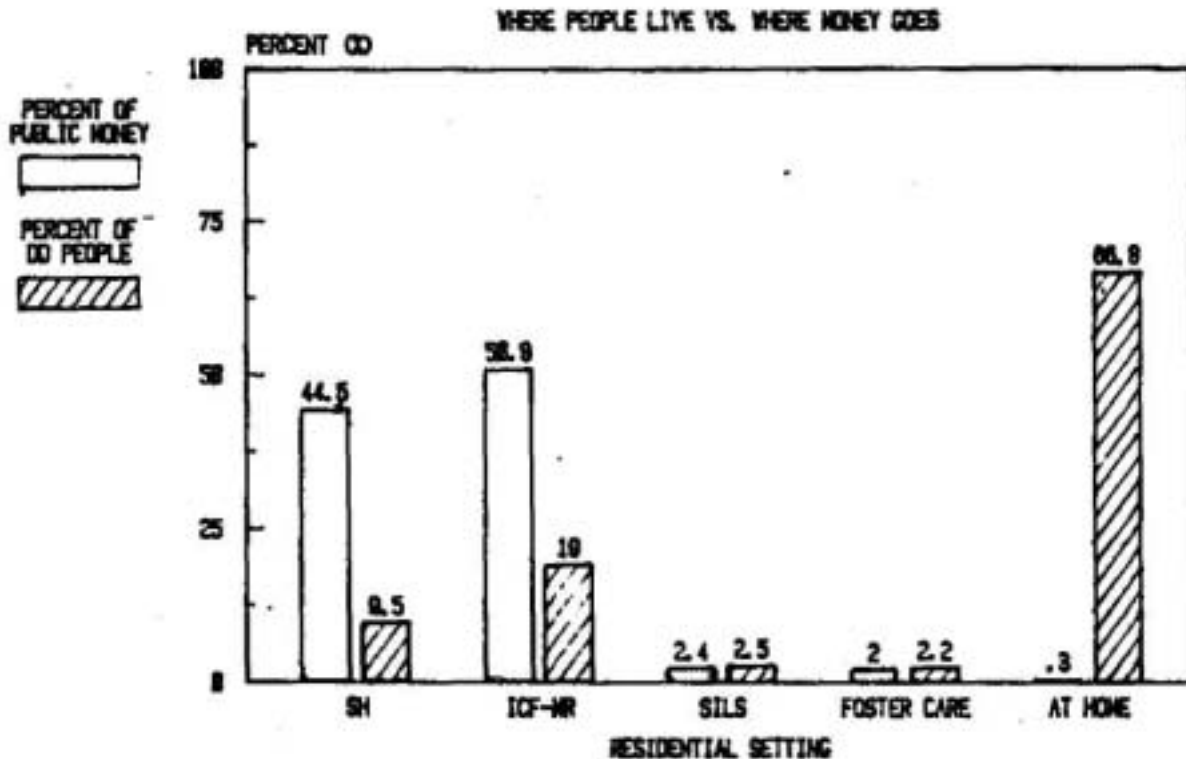
1. Title III services available only to those aged 60 and above.
2. Includes SNF, ICF, ICF-HR, and related therapies provided in nursing homes.
3. Includes home health services, nursing and personal care services, and transportation.
4. Total Title XX budget, all services and all ages.
5. Includes homemaker, chore, adult day care, home-delivered and congregate meals, transportation, adult protective services and adult foster care.
6. Includes all services. Federal and state funds only.

Besides skilled and intermediate-level nursing home care, Minnesota's Medicaid program also pays for three categories of community-based long term care services: home health services, medical transportation and personal (attendant) care services. In Minnesota in 1980, \$6.5 million was spent on these three services for all age groups. This compares to \$311 million for institutionally based long-term care out of a total Medicaid budget of \$566 million. Thus, 55 cents out of every Medicaid dollar was spent for nursing home care, as contrasted with one cent for non-institutional long-term care. About two cents of every Medicaid dollar spent for long-term care was for community-based care with the balance of 98 cents for institutional care.

Counties in Minnesota have substantial financial reasons to prefer placing elderly residents in costly nursing home settings as opposed to less restrictive settings. For example, counties only pay 4 percent of an elderly persons medical costs if they are institutionalized when that care is provided. In contrast, if the same care were to be delivered to the person in their home, a county could be held financially responsible for a larger share of the costs for the resulting care.

- 2) The Mentally Retarded- Lyle Wray, in his presentation to our committee, illustrated how much public funding for the mentally retarded goes toward state hospitals:

"Most of the state's mentally retarded budget goes to support state hospitals which serve a small minority of the state's mentally retarded population. For example, state hospitals serve 2,400 people who are mentally retarded at a total cost to the state of \$87 million. Group homes in Minnesota serve 5,000 at a total cost of \$67 million." (Minutes December 13, 1982). This relationship can also be described graphically as follows:



SOURCES: Office of Legislative Auditor (1983), P.22 Developmental Disabilities Program (1983)

The net result of the interrelationship of federal, state and local (county) funding sources is that a set of fiscal disincentives emerge which discourage deinstitutionalization. Tom Chapel of the Metropolitan Council staff has documented that these disincentives tend to discourage people from moving from state hospitals to community residential facilities (group homes) as well as from the latter facilities to other, less intensive

arrangements. Finally, Chapel documented that the same kinds of fiscal disincentives may constrain parents from caring for their mentally retarded children at home.

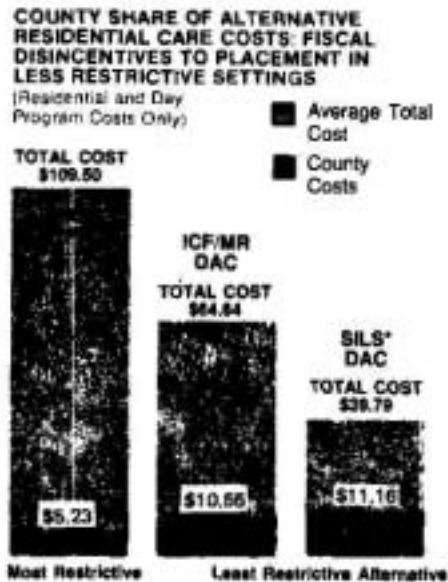
* Fiscal disincentives deter people's release from state hospitals

Federal regulations require that group homes provide active training and rehabilitation services to all residents. In Minnesota, this requirement has been met by having such training services provided outside the residential facility itself, in developmental achievement centers (DAC's). Because counties seek to maximize their use of entitlement programs, such as Medicaid, significant problems are created. Although Medicaid funds both state hospital and group home placements, the per diems do not include the same services. State hospital per diems include the cost of developmental programs while the group home per diems do not. Developmental programs for group home residents are financed by CSSA or county revenue alone. Under present conditions counties generally pay at least half the cost of these services. As a result, when a county decides to purchase service for a mentally retarded resident, it faces a dilemma. Although the average cost of a group home is less expensive than state hospital care, a county's share of total costs (residential and developmental) are higher in the group home setting than in the state hospital. Thus counties have financial incentives to purchase care from state hospitals rather than group homes because they can avoid the high CSSA matching rate for developmental programs.

This situation has been made worse by the 9 counties' own fiscal problems. Strained budgets have led some counties' to cut back on developmental services for the retarded. Under these circumstances, county residents living in state hospitals are unlikely to be released since state hospitals are reluctant to discharge residents without the assurance of full time day developmental programs. And group homes are reluctant to accept new residents who lack financial support for these services.

* Fiscal disincentives also deter people from being released from group homes to less restrictive settings.

Due to the fiscal disincentives involved, counties face even more problems attempting to move mentally retarded residents from group homes to other settings. In comparison to state hospitals and ICF-MR's, alternatives like adult foster care, supervised apartments or independent living arrangements all have unstable funding sources and require counties to secure such funding from a variety of sources or provide it themselves. Thus, even though the total cost, to government, of these alternatives is substantially less, the costs to counties of administering such arrangements and paying their share of the costs increases to such a point as to make such options non-cost-effective. (See table on next page).



- Fiscal disincentives deter families from taking care of their retarded children at home.

SSI eligibility for children is based on parental income unless the child is in an out of home placement. Since Medicaid eligibility is tied to SSI, families are driven to institutionalize the child in order to obtain public assistance with their medical bills, even though the child could be served more cost effectively at home.

In Minnesota, a similar disincentive operates, although its effect is less severe. For foster care, respite care and similar non-institutional services, parent contributions are determined according to a fee schedule. Current practice allows each county to develop its own schedule and to use different schedules for each service. Consequently, charges vary widely from county to county. Such fee schedules constitute still another incentive to place the child in a group home or state hospital where standardized fee schedules - which are much less costly to parents - apply.

- 3) The Mentally Ill- According to statistics provided by the Minnesota Mental Health Advocates Coalition, "80 percent of Minnesota's mental health dollars are spent on institutions which serve 1,500 people. Only 20 percent of the state's mental health dollars are spent on community treatment programs that could serve up to 30,000 patients.

The mental health system, like the mental retardation system gives counties clear incentives to institutionalize people in state hospitals instead of community alternatives. A Legislative Auditor's Report (February, 1981) concluded:

"Our study of the funding patterns for residential facilities and of the financial role of the county in providing funding has led us to the conclusion that counties have a clear financial incentive to place mentally ill persons in state hospitals, not community-based facilities. The county share of costs to support persons in state hospitals is fixed at a minuscule level while its share for persons in community-based facilities is sometimes substantial."

Of the approximately \$295 million spent for treatment of mental illness in Minnesota in 1980, only slightly more than \$12.7 million was dedicated to community-based rehabilitation and treatment programs.

Federal funding incentives have had a great deal to do with the shape of the existing mental health system. The requirements for receiving Medicare and Medicaid have often encouraged the use of public and private hospitals and the inappropriate placement of released patients into nursing homes. Medicare, for example, offers only limited coverage for out-patient mental health. Medicaid has been a more significant factor than Medicare in the funding of mental health treatment and encouraging deinstitutionalization. However, because the supply of community facilities has been somewhat limited and because Medicaid funding has been readily available for intermediate care facilities and skilled nursing facilities, states have had an incentive to release the mentally disabled to nursing homes.

- 4) Juvenile Justice- Both federal and state funding policies encourage deinstitutionalization of juvenile offenders. Although the impacts of federal programs and Minnesota's Community Corrections Act have lead to reduced admissions at the two state training schools (Red Wing, Sauk Centre), they have lead to increases in admissions to county-run facilities. Statewide, for example, between 1979 and 1982 the number of juveniles committed to residential facilities remained constant. But the distribution of juveniles in placement changed substantially. Decreases in admissions to state run facilities were matched by increased admissions at the county level.

Aside from publicly funded programs, the availability of private insurance has been shown to encourage juvenile placements in psychiatric and chemical dependency treatment centers.

- 5) Chemical Dependency- A December 1982 study prepared for the Minnesota Department of Public Welfare by the Health Policy Research Group at the University of Minnesota contained the following conclusion:

"There is little doubt that the current system of funding for chemical dependency creates a bias towards certain types of services or modes of care. There are both direct and indirect examples of this bias. The direct examples relate to specific restrictions within funding sources which limit treatment choices. Individuals eligible for federal Medicare and Medicaid programs must receive treatment provided at hospitals or nursing homes or through hospital outpatient programs or out-patient clinics directed by a physician. As a result, 80 percent of treatment provided through Medicaid and Medicare is residential."

State programs exhibit the same bias. For example, the State General Assistance Medical Care Program only reimburses chemical dependency treatment in hospitals or in hospital out-patient programs which are directed by a physician. Moreover, recent changes in the state's General Assistance Medical Care program reduced funds to counties for chemical dependency treatment. These reductions accompanied reductions in county social services budgets, resulting in incentives to place people in need of chemical dependency treatment in state hospitals as opposed to private, outpatient treatment. Such practices, according to the University report to DEW are "costly, inhibit family involvement in treatment, and raise questions about the appropriateness of care provided."

The net result of these funding patterns, according to the Health Policy Analysis Group Report:

"is that the chemical dependency treatment system in Minnesota has been dominated by residential or in-patient programs. Studies of chemical dependency treatment indicate that a complete system needs both in-patient and out-patient models not only because of cost differences but because the different models are designed to reach different target populations. Non-residential programs generally cost significantly less than residential programs; there is substantial concern about the appropriateness of using the residential model for all clients merely because it is the only model that will be reimbursed."

IV. THE CENTRAL CONTROVERSY IN EACH SYSTEM IS WHETHER PRESENT INTENSIVE UTILIZATION OF RESIDENTIAL CARE FACILITIES IS APPROPRIATE.

A. Substantial evidence exists which seems to indicate that some Minnesotans are being inappropriately retained in residential treatment facilities.

- 1.) The Elderly- Many studies have shown that patients currently in residential health care facilities do not actually require that level of care. In long-term care of the elderly, for example, a

1977 Congressional Budget Office Report estimated that 20-50 percent of the nursing home population could be cared for at less intensive levels of care. Two other reports issued in 1979 by the U.S. Comptroller General's Office and U.S. Department of Health and Human Services also came to the same conclusion.

A variety of differing estimates exist of the elderly population currently living in nursing homes who could be successfully deinstitutionalized, Leonard Levine, the current Commissioner of the state's Department of Public Welfare, in an April 1983 speech to the Citizens League, observed that:

"Jay Greenberg, (then) Sociologist and Economist for the University of Minnesota Center for Health Services Research, has conservatively estimated that 40 percent of Minnesota's nursing homes' residents don't need the level of care available in such a facility. Other estimates put that number as high as 66 percent."

Levine calculated that "with 93 percent of Minnesota's 40,000 nursing home beds filled, it means that we have about 37,200 nursing home residents," of whom "14,880 are in those homes unnecessarily -- nearly all supported by public assistance." Levine said that it costs the state about \$27 million dollars per month for "those people who could be elsewhere, and would probably prefer to be elsewhere, were there an elsewhere to be."

Greenberg, himself, however disputes the magnitude of such deinstitutionalization estimates. Greenberg told the CL staff that a 1974 Citizens Council on Aging study found that, at most, 18 percent of the elderly population in state nursing homes have the same characteristics as the non-institutionalized elderly population. But even within that population, according to Greenberg perhaps only 9 percent could be treated less expensively outside the nursing home.

More recent studies, such as a 1978 DPW report entitled: "Cost Containment Study: Home Care", estimated that between 639 and 1,489 elderly residents of Minnesota nursing homes had a good to moderate potential of returning to independent living. The most recent analysis, by Nancy Anderson and Sharon Patten of the Hubert H. Humphrey Institute of Public Affairs (June, 1980) suggests that twenty-two percent of nursing home residents had similar demographic and functional characteristics as home care clients. Their analysis however, did not provide estimates of nursing home residents who might be deinstitutionalized.

Others have also questioned whether it would be in the best interests of frail or elderly people to move them out of nursing homes. Even if that were possible and desirable from residents' point of view, critics say, how long would their eventual re-admittance into a nursing home be deterred?

While there is some potential to rehabilitate nursing home residents to the point where a return to community living is feasible, there appears to be more potential for delaying entry into nursing homes. Under the state's Alternative Care Grant Program, initiated by Senator Linda Berglin, all Minnesota counties were required to screen candidates for nursing home care beginning last July. Prior to that, 37 of the state's 87 counties voluntarily initiated such screening programs. As a result, over a 15-month period, 737 of 1,646 elderly applicants (44.7%) for nursing home beds, were diverted to home-based services.

- 2) Mentally Retarded- Despite all of the efforts to achieve deinstitutionalization in recent years, a 1983 report by the Legislative Auditor found that there were more mentally retarded people in residential treatment today than there were in the 1960's. In the 1960's, more than 6,000 retarded persons lived in Minnesota's state hospitals. In 1978, the average population in hospitals and community facilities was about 6,300. Moreover, the report stated, "the total number of mentally retarded persons in long-term care settings - state hospitals and community - settings has increased steadily in recent years." By 1982, the average population in hospitals and community facilities had increased to more than 7,100, the report said.

The Welsch versus Levine Consent Decree obligates the state to reduce state hospital populations by 545 persons by 1987.

A variety of other sources indicate that there are already many mentally retarded people with the capacity to function well in more independent settings. These people are ready to move to less restrictive settings. For example:

- The Quality Assurance and Review Program of the Department of Health estimates from client records that as many as 200 people in Minnesota should be ready to leave group homes for semi-independent living. (Source: Governor's Planning Council on Developmental Disabilities, February, 1983)
- Copeland and Iverson's (1981) Fiscal and Programmatic Assessment of Minnesota plans for deinstitutionalization cites an estimated 1,000 ICF/MR residents who could move to non-medical residential treatment with varying levels of supervision. Such alternatives could include foster care or SILS (semi-independent living services).
- According to the Governor's Planning Council on Developmental Disabilities, about 450 people in DAC programs who are ready for work activity services are not receiving them. An additional 240 people are ready for placement in sheltered workshops. Finally, there are about 450 people on waiting lists for DACs.

- 3) The Mentally Ill- Recent data indicates that at least 50% of all state hospital admissions were readmissions, due in large part to the absence of community alternatives. Some people, including the Minnesota Mental Health Advocates Coalition believe that more could be done for these people in community residential facilities.
- 4) Juvenile Justice- Since 1978, the incarceration of status offenders has been illegal in Minnesota. But nothing prevents a juvenile court judge from ordering a youngster into treatment for emotional problems or chemical dependency. And parents can place their children in treatment even if the child objects, without a commitment hearing.

A study by the Minnesota Supreme Court Juvenile Justice Study Commission (1982) showed that based on a sample of ten counties, there were approximately 2,000 pure status offense cases in Minnesota from July, 1979 to June, 1980. The Commission found that almost one-third of these youngsters received an out-of-home placement as their final disposition. As a result, the Commission recommended that all status offenders be removed from the juvenile court's delinquency jurisdiction and handled under separate jurisdictional categories. The Minnesota Legislature in 1982, acting in part as a result of the Commission's recommendations, removed status offenders from the delinquency category and allowed the police and schools to issue citations to juvenile offenders. The result has been that more, not less, of these cases are coming into the courts. Moreover, under the 1982 law, juvenile judges retain the ability to use treatment in an out-of-home placement for such ill-defined offenses as truancy, use of alcoholic substances, running away and being "wayward".

Aside from status offenses, there are other problems with Minnesota's juvenile and child welfare systems. Such problems include:

- Although national standards have urged an all-out ban on the use of jails for the purpose of incarcerating juveniles, data indicates that 4,000 children were admitted to jails in Minnesota in 1981. 1,400 of these children were confined in jails for over six hours.
- Anecdotal evidence suggests that children are being inappropriately retained in treatment facilities in order to allow providers to continue to collect public reimbursement.
- Terry Murphy, in a recent article for MPLS.-ST. PAUL magazine quoted a former supervisor of the St. Joseph's Home for Children as saying that 4 of the 12 youths in one cottage were ready to go home shortly before he left in September, 1982. More than six months later, the former official was shocked to learn that

those 4 kids "were still at St. Joseph's, bringing in \$95 a day each." Murphy calculated that four kids at that rate would be worth over \$69,000 to the home. "The question became," the former supervisor said, "whether they were concerned about kids or hooked on the politics of staying solvent."

- There appears to be a troublingly high number of serial placements.

According to the Hennepin County COUNTER BUDGET prepared by the Minneapolis Urban Coalition and Council of Churches, nearly 50 percent of the youths awaiting placement in Hennepin County in mid-1981 had been placed at least once before; 11.5 percent had already been placed three or more times as a juvenile. Additionally, among those children waiting a placement, only 31.7 percent were presently at home, suggesting that close to 70 percent faced at least a second successive placement out-of-home.

Even more troubling trends have been noted with respect to child welfare placements. Mary Duroche, a graduate student at the Humphrey Institute of Public Affairs, in a recent paper for the Center for Urban and Regional Affairs (CURA) found that a disproportionate number of Indian children were being placed in foster homes. Acting in what they believed to be the "best interests of the child," Duroche found that:

"Non-Indian child welfare workers applied the community standards to reservation situations, often equating Indian poverty with child neglect. Indian children were frequently placed in non-Indian foster homes to await adoption by non-Indian families. Those Indians who might have provided foster care were deemed unsuitable because their homes did not measure up to state standards. Indian parental rights were terminated without due process for Indian parents and relatives ... The process was seen by Indians not merely as a destruction of individual families but as a form of cultural genocide."

Duroches' study found that such practices predated the Indian Child Welfare Act of 1978. In 1974, an Association on American Indian Affairs survey found that approximately one out of every eight Minnesota Indian children was in an adoptive home and one out of four Indian infants (under one year of age) was in pre-adoptive foster care. By 1977, when the AIAA survey was repeated, the results indicated that Minnesota had the third highest rate of Indian child foster placements of any state in the nation - most of them in non-Indian homes. As Duroches study states, "Indian children here were five times more likely than non-Indian children to be placed in foster or adoptive homes." Ninety percent of adoptions for Minnesota's Indian children were by non-Indian couples. Only as a result of intense demands by Minnesota and

national Indian leaders did the U.S. Office of Civil Rights finally step in and order the Minnesota Department of Public Welfare to stop such practices.

- 5) The Chemically Dependent- In 1981, Blue Cross/Blue Shield of Minnesota instituted a program designed to assure that psychiatric and chemical dependency treatment provided to subscribers was undertaken in the most appropriate, cost-effective setting based on the patient's needs. While the program did not question the need for treatment, it did question the appropriateness of treating a high percentage of patients in in-patient settings, particularly for predetermined amounts of time. Under the terms of the program Blue Cross/Blue Shield asked providers to sign agreements committing them to paying for the cost of any care determined to be medically unnecessary.

As a result of the program, Blue Cross/Blue Shield denied payment for the equivalent of more than ten and one-half years of inpatient psychiatric and chemical dependency treatment in 1982. The Program reviewed a total of 1,724 claims involving 35,329 days of in-patient care at hospitals and freestanding chemical dependency centers across the state. Independent peer reviewers found 3,891 of these days medically unnecessary, or 11 percent of total days reviewed.

According to Blue Cross/Blue Shield, most (72 percent) of the treatment charges denied under the program were for chemical dependency treatment. Twenty percent of the total 16,654 days of in-patient chemical dependency treatment were found to be medically unnecessary.

- B. A growing body of research has led many to question the reasons for confinement and its effectiveness as a therapeutic measure. Although not conclusive, studies indicate that there is often little difference between the effectiveness of institutional and community care.

- 1) The Elderly- According to a 1982 report by the General Accounting Office, "when expanded home care services were made available to the chronically ill elderly, longevity and client-reported satisfaction improved." But, the report said, "these services did not reduce nursing home or hospital use or total service costs."

There continue to be conflicting reports on whether the availability of home health care could reduce the Government's costs for nursing homes and hospitals.

The General Accounting Office study concluded that:

"While expanded home health care benefits should provide valuable services to the nation's elderly, increasing the numbers of people eligible for care and liberalizing coverage of services would increase the overall health bill."

But the experience in Oregon, where home health care has been substituted for nursing home care wherever possible suggests that savings can result. Robert S. Zeigen, of the state Senior Services Division said home care has reduced the nursing home population by 5 percent since February 1982 with savings of \$1 million a month.

Those who believe that expanding home care benefits would increase costs premise that belief on the grounds that publicly supported services would lead to family abandonment and promote clients caning out of the woodwork to obtain service. Neither of these fears is justified according to a 1983 article in the Gerontologist by Alan Sager, Ph.D.. Encouraging home care has not lead to family abandonment, Sager wrote, "families ... continued to provide almost three-quarters of all help even when considerable amounts of publicly funded service (averaging 18 hours weekly) were given." interestingly, Sager found that "both clients and families tended to ask for somewhat less paid help than professionals suggested." This suggested to Sager that the elderly "seemed to value their privacy and independence more than they valued paid help."

The latter finding was echoed locally in a recent Survey of the elderly population by the Metropolitan Council's Housing, Health and Aging Program. The survey showed that most older people surveyed preferred their current living situation (single family home). When asked about service needs, the older people surveyed who needed extra assistance with daily living activities usually preferred to receive this help through informal sources such as family, friends, or neighbors, rather than formal service agencies.

The only local study to attempt an in-depth comparison of home care and nursing home care in Minnesota was completed in June 1980 by Nancy Anderson, Sharon Patten and Jay Greenberg. Their study compared 550 clients of seven home nursing and/or homemaker agencies with approximately 450 residents of eleven nursing homes. The major findings of this study are presented below.

- Demographic Comparison- Significant differences were noted between the two populations. Nursing home residents were older (average age 82 compared to an average age of 76 for home care clients), less likely to be female or married and more likely to have had a white collar occupation.
- Functional Capacity and Health Status- Both home care and nursing home groups were found, on average, to be somewhat in capacitated. But the range of incapacity within each group was substantial. Home care respondents were less incapacitated than the nursing home sample, although they were found to be more

functionally incapacitated than the nursing home ICF subgroup. Nursing home residents showed considerably greater impairment in mental functioning than the home care sample.

- Service Utilization- On average, SNF and ICF residents used significantly more services than the home care sample. A small proportion of home care clients accounted for most of the service usage.
 - Well Being of Respondents- Over 75 percent of the people in both settings expressed satisfaction with the services provided them. Home care respondents however, tended to be more satisfied than the nursing home sample. Although neither population appeared to be socially isolated, the home care respondents tended to have higher scores on an evaluation measuring degree of social contact. Nursing home residents were more satisfied with life in general, their family lives and their use of time than the home care sample although the latter group perceived themselves as having more choices. Over 90 percent of each sample were satisfied with their living arrangements and 75 percent of both groups said they would not prefer to live elsewhere. However, the proportion of home care respondents satisfied with living arrangements is statistically, significantly greater than the proportion of nursing home residents.
- 2) Mental Retardation- Studies comparing the adaptive progress of mentally retarded persons in community residential facilities and state hospitals show that community treatment is generally more effective.

Two types of research have been done. The first consists of longitudinal research – analysis of data on individuals residing in institutions and follow-up analysis of the same individuals after placement in the community for a period of time. The second type of research has been cross-sectional, involving the comparison of individuals in institutional and community settings. These individuals have been "matched" on key characteristics such as age and level of disability.

The most significant study thus far, however, has been Temple University's A MATCHED COMPARISON STUDY OF COST-EFFECTIVENESS: INSTITUTIONALIZED AND DE-INSTITUTIONALIZED CLIENTS. Starting in July 1979, the Office of Human Development Services (DHHS) in conjunction with Temple University conducted a research study to determine the impact of the court-ordered deinstitutionalization of the Pennhurst State School and Hospital. The study compared 70 people who were former residents of Pennhurst with 70 current residents.

The study took special care to match people by such traits as gender, level of retardation, IQ, years institutionalized, and a

pre-location self-sufficiency score. The findings showed that those mentally retarded persons living in the community had been at least as impaired as those still living in the hospital.

The results of the study found statistically significant differences between the deinstitutionalized group and the institutionalized group. Mentally retarded persons living in the community were found to have significantly improved the skills needed for everyday life and showed much higher levels of adaptive behavior.

A third major body of research consists of attempts to differentiate between various types of institutional and community facilities and to identify the factors which are responsible for creating changes in residents behavior. Much of this research has centered on facility size and has concluded that size, by itself, is not a definitive predictor of care practices or the behavioral development of residents. While small size per se is neither necessary nor sufficient to ensure appropriate care, research has shown that certain service attributes which are influential in producing gains in adaptive behavior and general development growth are more likely to prevail in smaller facilities. These attributes include:

- individualized attention (Baroff, 1980)
- resident oriented care practices (Balla, 1976)
- absences of security features, existence of personal effects, privacy in bathrooms and bedroom areas (Balla, 1976 and Baroff, 1980)
- community exposure/social interaction (Crawford 1979)
- experienced, trained direct care staff (Dellinger and Shope, 1978)

Finally, a number of studies have reported positive attitudes toward community living arrangements on the part of deinstitutionalized persons. The vast majority of people studied expressed considerable satisfaction with their community placements in contrast to their feelings about institutional life (Scheerenberger and Feisenthal, 1977.)

- 3) Mentally Ill - In a December 22, 1983 article in the New England Journal of Medicine, Loren R. Mosher, M.D. summarized the current state of thinking about the effectiveness of in-patient versus out-patient treatment of mental illness. According to **Mosher:** .

"Two major recent reviews and a doctoral dissertation, written by scientists with no obvious axes to grind, have pointed out that every study (7 in one review, 10 in the other, and 20 in the dissertation) comparing non-hospital with in-hospital psychiatric treatment has found the former to be as good as or better than the latter, and usually cheaper."

Mosher notes that the studies were not biased by the presence of large numbers of patients in the out-patient groups who were not ill enough to require hospitalization. Only those studies involving seriously disturbed patients in which there was random assignment of patients to a mental hospital or to some alternative form of care were used. Surprisingly, hospital treated patients in the studies were more often readmitted to the hospital than alternatively treated patients, leading one reviewer, C.A. Kiesler to note that psychiatric hospitalization seemed to be a self-perpetuating phenomenon.

Finally, Mosher noted that economic analysis favored alternative care by a 40 percent cost differential. The consistent financial advantage to alternative treatments existed despite differences in the interventions (ranging from residential care with surrogate peer staff to home visits by nurses), research methods, and types of patients studied.

Mosher points out that modern practices with respect to treatment of the mentally ill are bitterly at odds with existing research. Twenty-five percent of all hospital days are for mental disorder. 70 percent of all mental health dollars are spent on in-patient care and psychiatric admissions to hospitals without separate psychiatric wards are increasing rapidly.

Why, Mosher asks, have cost-effective alternatives not been widely utilized? There are three reasons. First, because third party payers have been unwilling to fund out-patient care. Second, American physicians, patients, and the public have come to expect that serious mental disorders will be treated in * hospitals. Such cultural expectations reinforce present practices and are not easily dissuaded. Third, today's psychiatry prides itself on being scientific. The relationship of the profession to the hospital is symbolic of the rapprochement that has taken place between psychiatry and medicine and is not easily dislodged.

The Minnesota Legislature, in its 1981 session, approved an appropriation for the funding of Rule 36 facilities (residential facilities serving five or more mentally ill people). In its Rule 36 Report to The Legislature, (March 1983) the Department of Public Welfare noted that while no data are yet available on the effectiveness of these facilities, they are quite similar to services provided under the Rule 14 Grant Program for the chronically mentally ill. Evaluations of those services showed that, "overall, residents experienced a significant reduction in psychiatric hospitalization while in the program." The report also contained the observations of staff from various counties regarding progress made under Rule 36:

- Facilities are reporting a substantial decrease in violent, assaultive and anti-social behavior.
- There has been a marked decrease in the withdrawn isolated behavior of people in residential treatment.
- People in treatment report a decrease in abusive situations and an increase in involvement in the decision-making process.
- There appears to be a trend toward residents moving to a less restrictive, more independent living setting on discharge.

4) Juvenile Justice- Former Minnesota Commissioner of Public Welfare Ed Dirkswager during his tenure in that office once wondered aloud at the "child centered" nature of the Juvenile Justice and Child Welfare Systems in Minnesota. He questioned whether these systems should become more "family centered." "Perhaps," Dirkswager stated, "we are guilty of ridding ourselves of the problem, rather than dealing with it in the home environment."

Recent efforts by Dakota and St. Louis counties are aimed at working with the families of delinquent youth as an alternative to out-of-home placement. Ramsey and Washington Counties have been especially active in this regard and the results of their activities are recounted below.

In October 1981, the Washington County Board contracted with Human Services Inc, to initiate a program to reduce the amount of adolescent residential placements while working with the children and their families in the home environment. The first phase of the program is an assessment process used to determine whether children could be diverted from residential placement and whether their families would cooperate with the goals of the program. A second phase involves individual interviews with family members, defining family problems and the establishment of goals to overcome them. A third phase involves several weekly counseling sessions with the family in their home. A final phase helps families learn about and utilize various community support networks - churches, friends, and neighbors. There is regular follow-up after program completion.

Some of the problems with which the program handles include children who have been physically or emotionally abused, truants and children with problems at school. The typical kinds of families in the programs often have multiple problems - domestic and legal. Some have been through the court system.

In 1982, the program's first year of operation, 41 kids were targeted for placement in various kinds of residential treatment facilities. The total projected cost of these placements was expected to be \$364,408. After subtracting the annual cost of the Family Treatment Program and the costs of the placements which did

not use the Program, the county reaped savings of \$124,157 as a direct result of the program. Moreover, families which completed all phases of the program were found to have an 88 percent chance of staying out of placement.

A representative of the Ramsey County's Community Human Services Department, told our committee of a project which evaluated the success of home-based versus traditional protection services.

Over time, the Ramsey County Board became dissatisfied with the number of children being placed in residential facilities and the high cost of that treatment. The representative stated that:

"We always said a child should go into placement temporarily, then go back home - we always said the right thing. But we reached the point where it almost became placement on demand. The parent said, "You take the kid," and we placed. When there was a lot of money, the tendency was to purchase the care. Our function became case-management, to coordinate the service, send Mom to the mental health center, the kid to a residential treatment center."

In 1981, Ramsey County created a home-based services project to work with families whose children would otherwise have been placed in residential treatment. Like the Washington County experiment, candidates for home-based services were initially screened. Demographic profiles of persons selected to obtain home-based services were similar to those slated to receive traditional child protection services. The experiment found that while the usual reason for referring children is thought to be problems exhibited by the child, in 82 percent of the intake assessments the precipitating problem had to do with parental functioning.

The key issue in the experiment was the manner in which county staff were deployed. Staff assigned to the home-based based services project saw themselves as actually providing direct service and counseling to persons assigned to them. Staff assigned to the more traditional control group saw themselves as case managers. As a result staff assigned to the home-based service units used out-of-home placement of children much less frequently (23%) than traditional units (45%). Duration of placement for home-based service unit children was much shorter (67 versus 119 days average) than children handled through traditional means. Not surprisingly then, notable differences were observed in the costs of placement. Home-based service cases involving out-of-home placement averaged \$1,491 per placement, whereas traditional placements averaged \$4,465. Total placement costs for home-based services children were \$11,931 as compared to \$80,377 for children in traditional placements.

In their July 27, 1983 report evaluating the project, Charles Lyle and John Nelson concluded that "in spite of the small number of cases, it is also appropriate to conclude that not placing children out of their homes is no more or less harmful than having them remain at home, at least as long as service continues to be provided to the family." Parents receiving home-based services improved at least as much, if not more than those receiving traditional services.

Ramsey County staff members affiliated with the project were clearly pleased with the results. Michael Geraghty, head of juvenile corrections, was quoted in a June 5, 1983, article in the St. Paul Pioneer Press as saying, "It's great, counselors will work one-to-one, keeping close tabs on these kids. Warehousing them (in institutions) isn't solving anything. They still come back to the same home."

Mary Beth Faimon, team leader of the home-based services project was quoted as saying:

"What I learned the most was from one client who talked about how she grew up in treatment centers and foster homes and always wanted that connection with her family. She's 25 and still looking for it. She would run away just to be with them, then be picked up and taken back to court or to a foster home. No matter how bad home was that's where she wanted to be, and all she met were social workers hell-bent on keeping her away from her family because they had bad reputations as drinkers and carousers."

- 5) Chemical Dependency- A March 1981 study prepared by the Chemical Dependency Program Division of the state Department of Public Welfare contained data concerning clients rates of chemical use following treatment in a variety of program settings. (See table on next page). In reviewing the table, it should be noted that the data are self-reported and therefore of unknown reliability. The data also come from clients who were followed up and people who fall into this category are more likely to express positive experiences than those who were not followed up. A third caveat is that the characteristics of people seen by these programs are quite different, making direct comparisons across settings invalid. Finally, it should be noted that state hospital populations serve a more difficult group than other programs.

Type of Program	Rate of 90 Abstinence days after program	Abstinence or Reduced Use 90 days after program
Primary Residential	59%	86%
Free Standing	63%	91%
Non-State Hospital	68%	93%
State Hospital	40%	69%
Other Residential	59%	85%
Halfway House		

SOURCE: Chemical Dependency Program Division, DEW, March 1981

Seven metropolitan area hospital-based chemical dependency programs have implemented an evaluation system called CATER (Collaborative Alcohol Treatment Outcome Registry). The CATOR 1982 report contains six-month and twelve-month follow-up results of patients who have undergone treatment for chemical dependency in both in-patient and out-patient settings.

The 1982 Cator Report found that "despite the higher levels of chemical use and greater impairment of in-patients than outpatients both groups showed similar outcomes in the post treatment phases. Over 50 percent of the in-patients and approximately 50 percent of the out-patients reported total abstinence for a full year after treatment. Another 25 percent of the in-patients and 30 percent of the out-patients reported substantial periods of abstinence during the year. Based on these results, program evaluators concluded that treatment program assignments were appropriate and commented that:

"It is noteworthy that out-patient services with their lower costs are adequate for a substantial part of the population ... With better assessment, it may be possible to divert more individuals to out-patient forms of therapy or to other innovative programs that can minimize cost while maintaining an appropriate level of efficacy."

V. THE TOTAL COST OF INSTITUTIONALIZED TREATMENT FOR THESE POPULATIONS IS VERY HIGH AND INCREASING RAPIDLY. AS A RESULT, THERE IS GROWING INTEREST IN OTHER KINDS OF CARE ARRANGEMENTS WHICH ARE LESS COSTLY.

A. The Cost of Treatment for Institutionalized Populations Is One of the Most Rapidly Growing Portions of the State's Budget.

Over time, the mix of public spending in Minnesota has changed in interesting ways. In 1954, education accounted for 40.6 percent of total spending, and in 1979, it was 35.8 percent. Health-welfare spending within the state has been a beneficiary of the new spending mix, with its share of the state's public spending per capita increasing from 15.6 percent in 1954 to 21.8 in 1980. (See table below.)

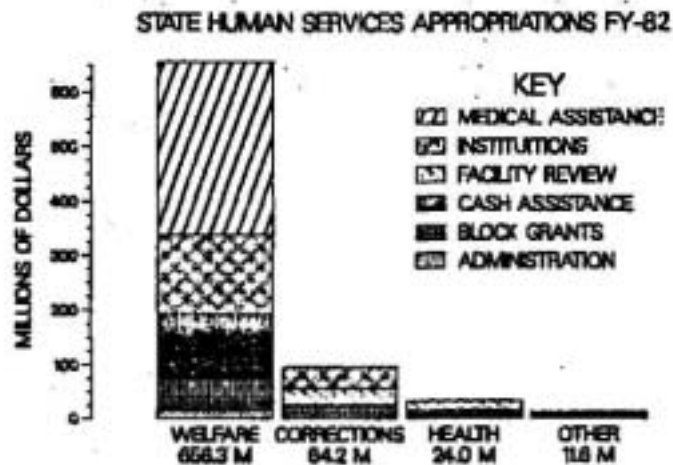
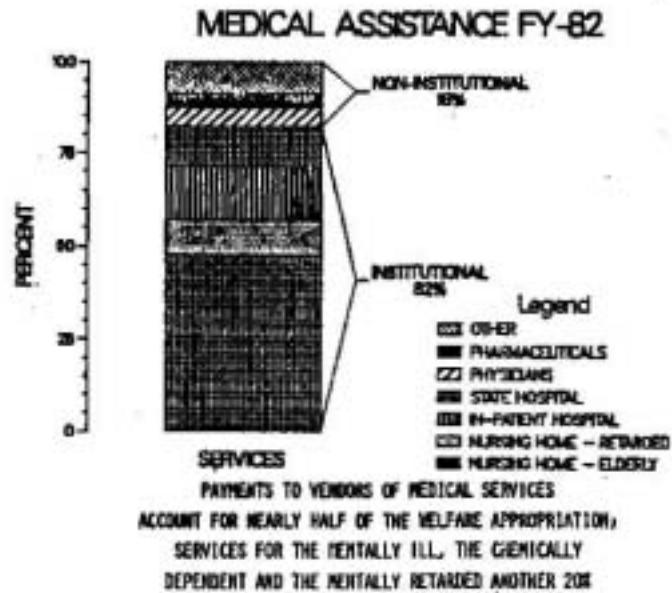
MINNESOTA SPENDING PER CAPITA, PERCENTAGE DISTRIBUTION

SERVICE AREA	1954	1980
Education	40.6%	35.8%
Highways	21.5%	11.5%
Health/Welfare	15.6%	21.8%
Other	22.3%	30.9%

SOURCE: ACIR, Significant Features of Fiscal Federalism, 1980-81;
Report of the Governor's Minnesota Tax Study Committee,
1956

According to Excerpts From Minnesota Horizons Human Services Presentation to the Minnesota Horizons Conference (January, 1983) by Earl Craig and Jan Smaby, in F.Y. 1982, the Minnesota Department of Public Welfare had a total budget of \$756.1 million. Of that total, 20 percent was spent on institutional services for the mentally ill, the mentally retarded and the chemically dependent. But that figure appears misleadingly small unless it is understood that within the state's medical assistance program (which accounts for nearly half of all welfare expenditures - first table below) fully 82 percent of all vendor payments are also "institutional" in the sense that they are received by hospitals and nursing homes. (See second graph next page.) As a result, nearly 70 percent of the DPW budget is directly related to "institutional" expenditures.

PAYMENTS TO NURSING HOMES AND HOSPITALS
ACCOUNT FOR 80% OF ALL MEDICAL ASSISTANCE EXPENDITURES



B. The Cost Of Providing Care to Vulnerable Populations Has Continued To Rise At A Rapid Pace.

- 1) Costs of Caring For the Elderly- According to a report prepared by the Center for Health Services Research at the University of Minnesota (Health Care Expenditures in Minnesota - 1980) total expenditures on nursing homes increased by 72.7 percent between 1976 and 1980. This rate of increase was somewhat lower than that experienced nationally (82 percent) but comparisons of per capita expenditures show that Minnesota spent \$108.51 as against the national figure of \$89.46.

Medicaid expenditures for nursing homes increased at a faster rate (99%) than total nursing home expenditures (79%) between 1976 and 1980. During that period, Medicaid expenditures increased at a rate of nearly 20% per year. Between 1976 and 1980, Minnesota Medicaid costs for persons in nursing homes increased twice as fast as the Medical Consumer Price Index. Nursing home expenditures have become the largest cost component of Medicaid, accounting for over 48 percent of total Medicaid expenditures in Minnesota and 40 percent of Medicaid expenditures nationally. Not surprisingly then, in F.Y. 1982, persons age 65 and older accounted for nearly 60 percent of Medicaid Assistance expenditures but represented only 20 percent of the recipients.

- 2) The Cost of Caring for the Mentally Retarded- According to a report by the Program Evaluation Division of the Office of the Legislative Auditor (1983), approximately 10,000 mentally retarded persons received publicly supported residential or developmental services in 1982, not including special education. (Private costs were not available.) Total costs which can be attributed to care for mentally retarded people were more than \$175 million in 1982, and residential care required 75 percent of this total.

Since 1971, Medicaid has paid for care provided by certified vendors to mentally retarded persons in state hospital programs, community residential facilities, and nursing homes. The cost of state hospitals and community facilities for the mentally retarded accounted for nearly 20 percent of the state's 1982 Medicaid expenditures.

- 3) Costs of Caring for the Mentally Ill- Between 1976 and 1980, the costs of caring for Minnesota's mentally ill population more than doubled, according to research by the University of Minnesota's Center for Health Services Research. Total public and private mental health expenditures in the state rose from \$139 million in 1976 to \$295 million in 1980.
- 4) costs of Caring for Juveniles- In February, 1983, the research department of the Minnesota House of Representatives released a report entitled, "Out-of-Home Placement of Children in Minnesota." The significance of the report lay in the fact that up until that time no one had calculated the total costs of the child placement system in Minnesota. The report found that in 1981, placement costs were estimated to have been more than \$185 million. To see that figure in its proper context, it must be understood that:

"Out-of-home placement is an expensive enterprise, particularly for the institutional treatment placements. The \$185 million costs are equivalent to about one-fifth of the state school aids spent to educate the children of Minnesota, but the total number of children in placement is only about 2 percent of the number of school children. A significant amount of this cost is paid for by tax dollars.

- 5) Costs of Caring for the Chemically Dependent- A 1983 Status Report by the Chemical Dependency Division within DPW found that total public and private chemical dependency costs rose from \$101.8 million in FY 1980 to \$115 million in FY 1983. the report found that state and local public shares of costs are decreasing while private and federal shares are increasing. In FY 1982, total state costs were \$26.8 million or 23.6 percent of all costs. Local costs amounted to \$13 million or 11.4 percent of total costs. The federal government assumed \$20.2 million of state chemical dependency costs or 17.5 percent. The private sector paid \$54 million in FY 1982 or 47 percent of total costs.

C. Where community alternatives exist, their costs, in general, are considerably lower than institutional costs.

In this section, we will briefly compare the costs of various alternatives for the five populations in our study. Readers should understand however, that an inherent difficulty in comparing the costs of residential with non-residential care is that additional costs such as housing, food, energy, transportation etc. must be factored in to non-residential care.

- 1) The Elderly- According to State Senator Linda Berglin, "monthly nursing home costs range from just over \$900 to nearly \$2,500 dollars." But the cost differences are even greater between institutional and in-home care. Nationally, hospital bills average \$350 a day per patient and the average stay costs \$3,675; nursing homes average \$57 a day and \$1,710 per stay.

The average cost of a home visit by a health professional is \$39. Care for the patient at home averages \$819 per month according to Government statistics cited by the New York Times.

Our committee visited with Bargee Righeimer, president of Nursing Care Service Professionals Inc., a local, for-profit, home health agency. She offered the following case studies:

- An elderly woman had severe arthritis and ulcers on both legs. As a result, she could not change the dressings on her legs. Hospital treatment for two weeks at \$350 per day would have rendered total costs of \$4,900. Two RN home visits per day for two weeks at \$28 per visit produced total costs of \$784.
- An 80 year old woman had cancer of the bile duct requiring daily irrigation. Righeimer's firm provided her with one visit per day of a licensed practical nurse at \$21 per day, \$588 per month, \$7,644 annually. Nursing home care for the woman would have run nearly \$2,000 per month or \$18,000 to \$24,000 annually.

- 2) Mentally Retarded- The following table shows the various costs of residential alternatives for developmentally disabled children.

COST OF RESIDENTIAL ALTERNATIVES FOR
DEVELOPMENTALLY DISABLED CHILDREN

Alternative	Per Diem
State Hospital	\$109.50
Community ICF/MR	49.97
SILS*	24.82
Foster Care	12.00

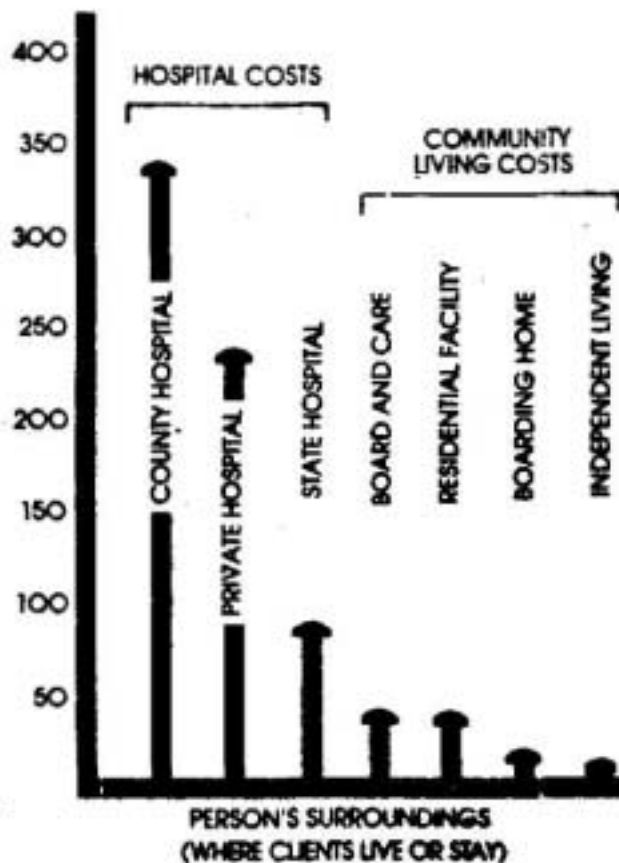
SOURCE: Governor's Planning Council on Developmental
Disabilities, 1983

* SILS (Semi-independent living services include supervision and
adaptive services - cooking, cleaning, riding the bus.)

- 3) Mental Illness- The following graph illustrates the per diem costs of various treatment settings for the mentally ill.

COSTS

(PER DIEM)



SOURCE: Roger Hellebuyck, MN Mental Health Advocates Coalition, 1982

- 4) Juvenile Justice- The table below illustrates the average per diem and average total cost for various treatment programs.

JUVENILE TREATMENT COSTS - MINNESOTA 1981

Type of Facility	Per Diem	Total Cost
Residential Treatment Center	\$84	\$25,200
Juvenile Correctional Center	\$77	\$ 9,240
Welfare Group Home	\$41	\$ 7,380
Corrections Group	\$20	\$ 4,200

SOURCE: Out-of-Home Placement in Minnesota: A Research Report, House Research, February, 1983

- 5) Chemical Dependency- The following table represents the cost of various treatment alternatives.

COST OF VARIOUS TREATMENT ALTERNATIVES FOR THE CHEMICALLY DEPENDENT

Type of Treatment	Per Diem	Total Cost
In-patient Hospital	\$89.57	\$2,721
Independent Residential	\$66.65	\$2,083
Out-patient (Hospital)	\$32.37	\$ 714
Out-patient Ind. Resid.	NA	\$ 732
Out-patient Clinics	NA	\$ 693

SOURCE: Citizens League Report: Next Steps in The Evolution of Chemical Dependency, 1980

VI. INCREASINGLY, POLICY MAKERS ARE FOCUSING THEIR ATTENTION ON WAYS TO CONTAIN THE SPIRALING COSTS OF INSTITUTIONAL CARE, SEVERAL APPROACHES ARE BEING DISCUSSED.

- A. Some people are suggesting that a stronger emphasis be placed on preadmission screening to avoid or delay unnecessary institutional care.

Preadmission screening is a form of assessment meant to determine the most appropriate level of care for a given individual. It has been widely, and successfully used in acute care. For example, the Foundation for Health Care Evaluation, a Twin Cities non-profit Foundation contracts with private employers to provide a "second opinion" before the employee enters the hospital. The Foundation also checks the length of stay when patients are discharged. Despite its relative youth, the Foundation already involves more employers than any other private review program in the country.

During its first year of contracting with private employers, (1981-82) the Foundation estimated that it saved employers \$6 million. In the first eight months of FY 1982, the Foundation was able to garner a 40 percent reduction in hospital days for covered personnel of participating companies. Much of the programs' benefits, spokesmen say, is simply making physicians aware that their styles of medical practice are being monitored.

Preadmission screening is now mandatory for publicly funded nursing home care in Minnesota. In the first six months of mandatory screening, from July through December 1983, 2,370 people were screened throughout the state and 58 percent were considered capable of staying home, according to Barb Colliander, the program's coordinator in the state welfare department.

It is also mandatory under the state's new civil commitment process for the mentally ill and has been proposed for the mentally retarded under the provisions of a potential new state waiver. Blue Cross/ Blue Shield of Minnesota has formulated some guidelines to review chemical dependency admissions and length of stay, but has not, as yet, begun to move in the direction of preadmission screening. (While BCBS put preadmission screening in place for its AWARE program physicians in October of 1983, it has not extended the program to cover either chemical dependency or psychiatric care.) Ramsey County is experimenting with citizen review panels before placing juveniles outside their homes. Some people believe that certain kinds of offenses should no longer be decided by the juvenile court or that mediation should be used instead.

B. Some people are suggesting policies which would substitute community care for institutional care.

Several policies have been suggested or are currently being implemented which have the effect of substituting community care for institutional care. They include:

- Subsidies or tax credits to families to take care of their family members at home - DPW already has a family subsidy program for the mentally retarded. It pays families up to \$250 per month. The program began in 1976 working with 50 families under a \$150,000 appropriation.
- Alternative Care Grants - Established by the legislature in 1981, the program allowed applicants to nursing homes who were age 65 and older and eligible for Medical Assistance to go before a special preadmission screening panel. The panel would make a recommendation on institutionalization based on the individual's health and available services. The individual was required to follow that recommendation. Legislative changes in 1983, however, allowed:

- * the recommendation of the screening team to become voluntary.
- * applicants already in acute care settings (i.e., hospitals) were required to apply for the alternative care grants in order to leave the institution.
- * the ceiling on the amount of money to be used was increased. Now the total cost of community care can be equal to the per diem cost of long-term institutional care.

In 1982, 935 persons throughout the state were participating in the alternative care grant program at a total cost of \$212,857.81.

Finally, as part of the original 1981 law, DEW submitted an application in May 1982 for a waiver on Federal Medical Assistance funds which would permit federal reimbursement for the alternative care services. This waiver has been approved and thus potentially doubles the amount of money available for alternative care services.

Minnesota's Alternative Care Grant Program in some ways resembles a nationally acclaimed program in New York. The Nursing Home Without Walls Program provides care to people in their homes who would otherwise be eligible for placement in a residential health care facility. In particular, the program is directed to the Medicaid eligible persons as a way of minimizing extensive public costs of institutionalization. A cap is placed on the expenditures for service provided under the program at 75% of the local average annual Medicaid cost for maintaining the patient at a comparable level in a residential health care facility. New York successfully sought a national waiver to allow Medicaid reimbursement for many services not originally covered. (Home maintenance, nutrition, education, respiratory therapy, respite care, social day care, transportation, congregate/home delivered meals, medical social services, etc.) Home care under the program can be offered by certified home health agencies (including county health departments) and hospitals, nursing homes and other residential health care facilities. Cost savings generated by the program have been impressive. 270 SNF level patients were served at home in November 1980 at an average cost of \$968 per patient. The average monthly cost for patients in a skilled nursing facility was \$1,956. The one month cost savings for these patients was \$366,651. Additionally, the program served 194 less acute patients who had formerly been housed in health related facilities. These patients were served by the program at an average cost of \$637 for the month of November 1980. By comparison, the average facility cost was \$1,238. Cost savings for these patients amounted to \$116,601, bringing total program savings for the month of November 1980 to \$383,252. For these same 464 patients over a years time, the savings would have been \$4,599,024 or about \$9,912 per patient.

- C. Others want to reduce the degree of "medicalization" in the systems by relying less on professionals and more on para-professionals, family members and volunteers.

Families and informal systems of care provide the largest proportion of care to vulnerable populations which require long-term chronic attention. National studies indicate that families provide 80 percent of all care. In the case of the elderly, studies show that "more people enter nursing homes due to a loss of family supports than from a change in physical condition."

According to a 1978 report by the Minnesota Department of Welfare (Cost Containment Study: Home Care) an estimated 325,000 Minnesota families care for impaired elderly, the physically disabled, and developmentally disabled persons in their homes. Only in a small minority of cases do these informal networks break down to the point where a more formalized, professional network is employed. In Minnesota, for example only:

- 9.2% of Minnesota's elderly population live in nursing homes.
- 2.5% of Minnesota's juvenile population are involved in out-of-home placements.
- 6% of Minnesota's mentally ill population receive residential treatment.
- 7% of Minnesota's mentally retarded population resides in state hospitals and residential facilities.
- 6.6% of Minnesota's chemically dependent population receives treatment in residential facilities.

Many of our speakers have commented that Minnesota does very little to help the family take care of its own members in the home. There is little public money devoted to home care or respite care. Consequently, when professional care is employed it often tends to supplant rather than supplement family care.

But many new arrangements are changing that. Hennepin county for example is thinking about a "care bank" where community volunteers log or bank hours helping the infirm. Then, when and if, those volunteers or their families need assistance, they may withdraw their help in the form of volunteer assistance by others.

The Saint Anthony Park Block Nurse Program uses an interesting new mix of professionals, paraprofessionals and family members to provide care. It uses registered nurses living within the neighborhood to provide nursing care to elderly residents who would otherwise be forced to enter nursing homes. Neighborhood residents who are trained as paraprofessionals at a local vo-tech institute are also employed to provide home health services, homemaking and chore services.

Services are arranged by a "primary block nurse" in conjunction with the person's family. Wherever possible, the family is taught to meet as many of the person's needs as possible. This helps to minimize over-dependence on costly professional help. During its first six months of operation, according to Marge Jamieson, the program helped to save over \$30,000.

- D. Some people want more stringent regulatory controls over the supply of beds and treatment facilities and "entry" into the care business.

Minnesota has used certificate of need to control the number and types of new health care facilities. CON has governed both in-patient and community type facilities for the elderly, and the mentally retarded as well as acute care chemical dependency and psychiatric beds.

But research shows that certificate of need has not been very effective in controlling capital costs. From January 1978 to September 1983, the Minnesota Department of Health approved 97.6% of the 368 certificates which came before it. The Metropolitan Health Board historically has also had a high percentage of approvals. The underlying cause of these high approval ratios was the lack of any organized political opposition to capital projects while a ready and well-organized support base could always be mustered by those supporting the project. Denying a certificate was often caricatured in the press as denying "legitimate human needs."

Mechanisms like certificate of need or moratoriums on bed expansion (now in effect in Minnesota for nursing homes and ICF-MR's for the mentally retarded) may also foster the following negative consequences:

- Restrictions on supply tend to keep poor quality providers in the system and assure their economic survival. Such restrictions also "condemn" consumers to using such facilities in the absence of other alternatives.
- Restrictions on supply may have the effect of keeping consumers in higher cost facilities. The occupancy rate in Minnesota's nursing homes has exceeded 90% for several years. Thus, it is extremely difficult and often impossible to find a long-term care bed for a patient who could otherwise be discharged from an acute care facility. As a result, patients remain "backed up" in even more costly hospital beds. (A recent study by the Statewide Professional Standards Review Council in New York found that in a one-day census of Medicare and Medicaid, five patients were awaiting placement for every long-term care bed open and available on the day of the census. New York has an average occupancy rate of 96% in its nursing home system.)

- Proposals which attempt to limit nursing home beds are particularly unwise now, since the federal government has shifted the entire acute care system towards payment on the basis of DRGs (Diagnostically Related Groups). This will shift the reimbursement system away from a per diem mode and encourage hospitals to discharge patients much faster than ever before. Some of these patients may continue to need some follow up care. If nursing home bed capacity is limited by state policy where will such patients go once the new, federal system takes effect?
- Research (Scanlon: "A Theory of the Nursing Home Market," 1980) indicates that "public policy has helped, to stabilize the market at a position where privately paying consumers obtain all the nursing home care they desire, and Medicaid recipients fill whatever beds remain after private demand has been satisfied."
- According to Feder and Scanlon, nursing homes are likely to use two criteria in selecting patients from the applicant pool: 1) To maximize their profits or net revenue, operators will prefer patients who pay more (private patients) to those who pay less (Medicaid patients) and 2) Patients who require a little attention to those who need considerable and costly attention.

This would seem to suggest that policies which attempt to limit capacity have the effect of discriminating against the poor.

- Finally, restrictions on supply prevents existing facilities from facing competition from new service providers.

B. Others are suggesting some competitive reforms.

Terry Sarazin, State Director of Programs for the Mentally Ill has suggested that the state take a hard look at the use of vouchers for mental health service consumers. Speaking at a Governor's Forum on Mental Health in June 1982, Sarazin stated that vouchers would enable consumers to negotiate with providers for units of counseling, thereby transferring power to people who now feel dependent on the system.

Lyle Wray, the court monitor for the Welch versus Levine consent decree, has argued that state hospitals be required to compete with community facilities in providing service to the mentally retarded. This could be accomplished, Wray said, by placing those funds which now go to the state hospital system in the CSSA account and allowing counties to decide the most appropriate way to use them. During his term as Mental Health Commissioner of the Department of Public Welfare, Dr. Ronald C. Young proposed something fairly similar to this concept by urging that Minnesota's mental health system be restructured so as to phase the state out of direct operation of the state hospitals. Under Young's proposal, although the state would divest itself of administrative control (state administration would be replaced by local/regional governance), the state would continue

to provide funds to regional and local programs serving chronically and severely impaired mentally ill, mentally retarded and chemically dependent persons. Commissioner Leonard Levine has also proposed some new policies in this area. However, both proposals met with vigorous community and labor opposition.

The most far-reaching competitive suggestion thus far, has been the creation of the Competitive Medicaid Demonstration Project.

In July, 1982, the State Department of Public Welfare, received a grant from the Federal Health Care Financing Administration to develop and implement a prepaid capitation demonstration project for Medicaid recipients in three or four Minnesota counties (one urban, one suburban, and two rural). The demonstration's primary goal is to develop a cost-effective, prepaid program for the administration and delivery of health services to Medicaid recipients. In the current health care system, providers are paid on a fee-for-service basis, where reimbursement is made after a service is rendered. The purpose of the project is to demonstrate whether and how a Medicaid program can be operated on essentially a fixed budget, where total expenditures are a function of the number of eligible clients and a predetermined amount paid by the State on their behalf. If successful, the demonstration should enable the State to better predict and budget its health care expenditures for the Medicaid population.

The main features of this project are summarized below:

- Target Population - All Medicaid eligible recipients in three or four counties; one urban, one suburban, and one or two rural. Eligible populations will include AFDC, Supplemental Security Income, Minnesota Supplemental Aid, and the medically needy.
- Participating Providers - Any organization (institutional, non-institutional, public or private) deemed by the State to be a legitimate provider of services for the Medicaid population will be eligible to participate. Participation will be optional but providers must meet a set of conditions established by DPW for the project.
- Service Delivery Structure - Because participating provider organizations must guarantee the full range of Medicaid-covered services, it is anticipated that umbrella organizations will be formed to serve the needs of the Medicaid population. These umbrella organizations will likely be composed of acute and long term care providers as well as allied health services such as pharmacies, dentists, optometrists, etc. The umbrella organizations will be responsible for accepting the prospective, capitated payment and arranging for the delivery of the appropriate medical and social services either directly or through subcontract with necessary providers.

- Payment arrangement - Prospective, per capita payment (a predetermined amount of money paid in advance for an individual) will be paid directly to the umbrella organization by the State. The capitation rates will represent some percentage of the projected average per capita cost of providing service to a particular individual based on a rate which is determined by age, sex and county of residence, with an additional "health status" adjustment for high risk populations. Payment arrangements among providers within an umbrella organization will be decided between the umbrella organization and their providers. Recipients will not be charged a co-pay for covered services, but may be charged for non-Medicaid-covered services.
- Risk Sharing - The State will share the financial risk with provider organizations for individual high cost cases, and in the event of overall losses due to adverse claims experience, during the first two years of the demonstration.
- Health Status Adjustment - High-risk Medicaid recipient categories will have their base capitation rates further adjusted for the individual's health status to minimize the impact of selection bias. The method of adjusting capitated rates will be created, tested, and applied under the demonstration.
- Enrollee- Benefits - The full range of Medicaid-covered services will be available through participating providers to meet the health care needs of recipients. Providers may also deliver substitute services such as homemaker services, respite care, etc. in place of the mandated Medicaid services.
- Suspension of Fee for Service - The existing Medicaid program will be suspended in the demonstration counties and recipients required to enroll with participating organizations if sufficient numbers of providers can be attracted to participate in the demonstration.
- Recipient Lock In - Recipients will be able to choose between umbrella organizations where a choice exists. After they have enrolled in an umbrella organization, they will be required to remain with that organization for one year.

VI. POLICYMAKERS ARE ALSO CONSIDERING NEW WAYS TO PAY FOR TREATMENT FOR INSTITUTIONALIZED POPULATIONS.

A. There is growing interest in prepaid systems of reimbursement.

Many people identify this form of reimbursement with Health Organization's because, for a prepaid fee, people are promised as much service as they require under a specified contractual arrangement. The Twin Cities, in particular, has had extensive experience with this type of arrangement. Almost 30 percent of metro area residents are members of an HMO.

The public sector has recently begun to adapt the idea of prospective reimbursement to a variety of medical entitlement programs. A local Medicare demonstration project, for example has sought to test the merits of efforts to enroll Medicare recipients in HMOs. At the federal level, prospective reimbursement is already in place in acute care with the implementation, last year, of a payment system based on diagnostically related groups (DRGs). With DRGs, the federal government agrees to pay a set amount per diagnosis.

The Minnesota Legislature, in its 1983 session approved a system of prospective reimbursement for the state's nursing home system under a proposal authored by Representative John Clawson and Senator Linda Berglin.

B. There is growing interest in outcome based reimbursement.

In a recent book, ("Long Term Care in Six Countries) the noted gerontologists Kane and Kane have described an outcome based system of reimbursement for long term care⁴⁷ Their system relies heavily on an independent assessment of nursing home patients at regular intervals. Each assessment establishes a prognosis for the patient for the next reimbursement period. Providers are reimbursed according to their ability to help the patient meet the prognosis. In each case, at least three outcomes are possible: the patients condition could exceed expectations; meet expectations or fall short of them. Under the Kane's system, different reimbursement levels would accompany each outcome. If the patient did better than expected, reimbursement would be 1.5 times the preestablished rate. If the patient did as well as expected, reimbursement would be one times the preestablished rate. Finally, for unsatisfactory progress, providers would be reimbursed at a rate of 0.5 times the preestablished rate.

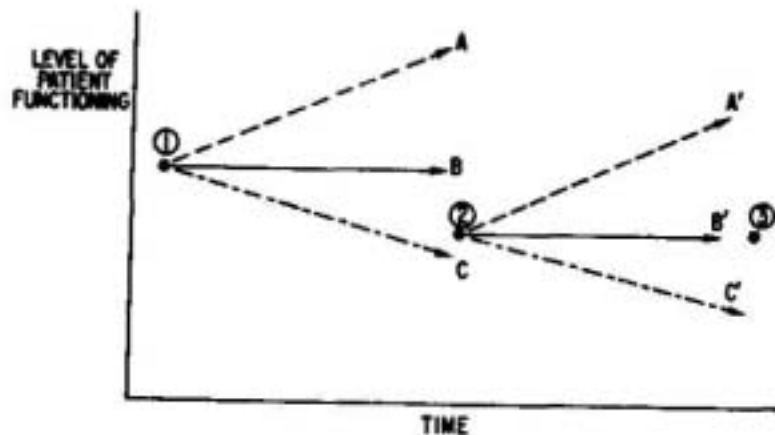
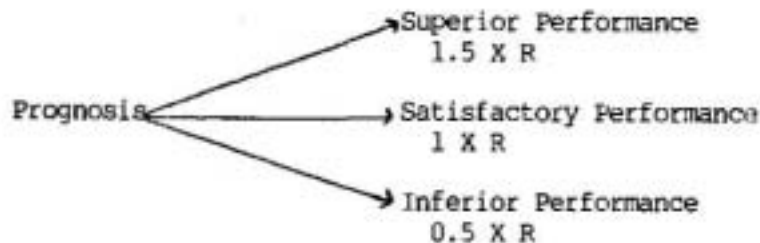


Figure 2. Diagrammatic representation of serial outcome assessments for a nursing-home patient. At time 1, the patient's prognosis for the subsequent period is projected. Basically, one may look for some degree of improvement (here represented by line A), or maintenance (line B), or a worsening state (line C). When the patient is reassessed at time 2, his actual outcome (shown as a point) is then compared to that prognosticated; if one had prognosticated a course along line C, the patient would be recorded as a positive outcome. However, if the prognosis had been along lines A or B, the outcome would be less than adequate. The actual outcome at time 2 serves as the basis for a new prognosis shown as A', B', or C'. These are in turn compared to actuality at time 3 and so on.

The Kanes have noted that their proposed system contains many advantages. Reimbursement on the basis of outcomes leaves a nursing home free to find the best way to achieve the desired outcomes. Nor would their system penalize a home for seriously ill patients "since a patient's outcome is compared to his individual prognosis." The Kane's have stated that:

"A patient may deteriorate and still do better than prognosticated and the more seriously ill patient will also have a higher base rate. Under such a system, the medical care and the nursing home services would be reimbursed as a single unit since these will be working synergistically; the nursing home could then contract out the medical care services."



Both New York and Iowa now use some outcome based measures of quality in their nursing home assessments. Iowa has been experimenting with this technique by studying about ten percent of the residents in 278 of the state's Intermediate Care Facilities. These residents are randomly selected and assessed based on their progress over time and how closely the prognosis for the resident matches the actual outcome. New York uses a screening mechanism based on patient conditions and outcomes in order to identify facilities which require further review.

C. There is growing interest in preferred provider arrangements.

PPOs are arrangements in which the services of a specified group of providers are offered to insurers or employers at predetermined rates based on a negotiated fee schedule. Unlike HMOs, however, consumers are not locked in to the provider group; they may use other physicians or hospitals if they choose. But here's the catch: Consumers who do use PPO services enjoy substantial financial rewards, including the waiver or reduction of co-payments or deductibles, or increased benefits. As can be expected, consumers choosing to use non-preferred providers must submit to financial penalties and, in some cases, reductions in benefits.

Because most PPOs do not try to lock in their patrons, they are much more flexible arrangements than HMOs. This flexibility should appeal to consumers who desire the cost-effectiveness of the HMO, but who

still value the ability to see their traditional fee-for-service family physician. Because of this flexibility, PPOs could provide a solution to the "claim-jumping phenomenon,"¹¹ where families switch from conventional coverage to prepaid coverage and back again to obtain certain benefits. Another difference between PPOs and their prepaid predecessor is that PPOs have no capitation feature. Each claim is processed and paid according to the negotiated schedule.

PPO's exist in San Diego, San Francisco, Denver, Los Angeles and several other areas of the country are actively exploring this option. In the Twin Cities, hospital corporations such as Fairview, United-MMC, and Abbott-Northwestern have indicated their intent to form PPOs. Several physicians groups are also reported to be organizing PPOs.

- D. Some people believe that chronically ill populations and their families should be charged fees, thereby contributing a greater proportion of the total costs of care.

A new federal interpretation of the Medicaid law by the Reagan Administration would allow states to require the children of elderly patients to help pay for nursing home care. Some states are moving in this direction. Indiana has passed a law to this effect. Virginia has also passed a law but to date has declined to enforce it. According to an article (March 30, 1983) in the St. Paul Dispatch and Pioneer Press, Wisconsin's legislature is considering a "family responsibility law."

The proposed Wisconsin law would establish a sliding scale for contributions by children with elderly parents in nursing homes. Children over 18 with taxable incomes of \$30,000 to \$35,000 per year would pay \$3.25 per day. Children with incomes of \$50,000 and above would contribute \$7.50 per day. In the event that such costs were a "severe hardship" to the adult son or daughter, the state would have the power to waive the co-payment.

- E. Finally, some people are suggesting a new mix of public and private financing mechanisms -- especially for the elderly.

The most obvious example of this trend has been the federal government's encouragement of IRAs--Independent Retirement accounts. IRAs can help individuals save for their retirement and the accumulation of such private assets may lessen the governments burden of financial responsibility.

The Metropolitan Council's "Plan for Housing and Services for Older Persons in the Metropolitan Area" (August, 1983) has made a recommendation on the question of how much responsibility older persons should have in paying for housing and services. It states:

"The older person should assume responsibility for costs related to the housing portion of his or her housing and service needs, and should pay for as much of any needed services as possible given the individual's financial circumstances."

Leading thinkers in the field of gerontology and long-term care such as Alice Kethley of Interstudy's Interage Program and Lu Molberg of the Webster Institute have begun to suggest that we begin to shift the responsibility for financing long-term care from the public to the private sector on a transitional basis. Under this scenario, government would, of course, continue to provide financially for the poor.

<u>Population</u>	<u>Characteristics</u>	<u>Potential Public Savings</u>
Age 75+	frail, chronic resources depleted dependent government re- sponsibility	Little Savings Primarily government responsibility
Age 60-75	healthy have resources independent co-responsi- bility over time	Some Savings A co-responsibility between government and the individual
Age 60 and under	healthy building resources independent self responsibility for aging	Considerable Savings Primarily an individual responsibility

SOURCE: Alice Kethley, Interstudy

The two most promising new financing mechanisms to help offset long-term care costs are long-term care insurance and home equity conversion. We will discuss each in turn.

Long-Term Care Insurance- According to Hark Meiners of the National Center for Health Services Research, the "most intriguing benefit from the development of a private market for long-term care insurance is the potential for relieving some of the pressure on Medicaid." Government payers, he observes, "would benefit if private insurance replaces Medicaid and other long-term care programs for the middle class, or at least slows down the spend-down process or negates the to divest assets." The problem, he states, "is that even those persons with personal resources that are quite adequate for a normal retirement will not be able to pay for long term care should it become necessary."

As evidence of his claim, Meiners notes that an estimated 54 percent of the elderly who enter a nursing home are not initially supported by Medicaid and most of those people pay more than 90 percent of their bill out of their own resources. Conversions from private pay status to Medicaid represent a major portion of nursing home residents supported by Medicaid. According to a General Accounting Office review of several studies, conversions represent 30 to 38 percent of the residents supported by Medicaid. While one study showed that many conversions occur shortly after admission, the majority (59 percent) converted sometime after a six-month stay."

To Meiners, these figures suggest that a significant number of those who entered nursing homes as private payers had sufficient resources to have purchased long-term care insurance, had it been available. Had they done so, "some 18 to 22 percent of those now on Medicaid might have avoided needing government support." Even if these estimates were off by a factor of two, Meiners concluded that the dollar savings in 1980 Medicaid costs might have been as high as ten percent (\$870 million). Those savings would have increased to \$1.9 billion by 1985 and \$3.4 billion by 1990, he estimated.

There is growing interest in insurance coverage for long-term care. A recent article in the New England Journal of Medicine (Katz, et. al, November 1983) used life table techniques to demonstrate the feasibility of forecasting remaining years of functional well-being for the elderly. Keeler, Kane and Solomon (1981) have argued that long-term care is a type of risk that is proper for insurance since there is a very high variance in costs: only 20 percent of the elderly will ever enter a nursing home and only five percent are residents at any one time.

In late 1981, the Governor's Task Force on Health Care Costs recommended to Governor Quie that Minnesota encourage private insurers to cover long-term care for the elderly. At least one local group, the Marquette Agency, now offers such a policy. But this plan, like many other prototypes surfacing nationally contains the same critical flaw

that is characteristic of the present delivery system -- a bias towards institutionalization. Home care and other support services are not covered. Dr. Hark Meiners has offered the only known policy proposal which overcomes that problem.

In an article for Health Affairs, a health policy journal, ("The Case for Long-Term Care Insurance") Meiners has suggested a long-term care insurance plan which focuses on nursing home care, is sold to the elderly at age 65 during a limited open period, covers a stay of up to three years after a ninety day deductible is met, and is an indemnity policy paying a fixed amount per day with a maximum payable limit. While the policy focuses on a nursing home stay, benefits are not limited to simply nursing home care. Rather the allowable cost of the nursing home stay serves as the basis for the upper limit of the insurance company's liability. And, most importantly, home health services could be substituted for care in the nursing home. Doing so, Meiners observes, "avoids a bias towards institutional care and provides the beneficiary the opportunity to shop around to obtain the maximum benefit for his premium dollar." Where non-institutional care costs more than nursing home care, beneficiaries would pay the difference out of pocket. Eligibility for home care benefits would be determined prior to institutionalization. However, since the intensity of utilization of home care services is as yet unknown, home care services would only be allowed after a covered nursing home stay begins. Although Meiners proposal does not specify the amount of coverage for home care under his prototype policy, he suggests several different approaches which could be used. One is to limit the period of coverage. Another is to limit the amount of home care visits. And a third way is to limit the amount paid per visit.

Home Equity Conversion enables elderly homeowners to remain in their homes by drawing down the equity in their property, resulting in an increase in disposable income.

Several communities around the country are exploring home equity conversion programs. These include Florida, Oregon, Wisconsin, the District of Columbia, San Francisco, California; Buffalo, New York; and Essex, New Jersey. The Minnesota Legislature in 1980 passed a measure authored by former State Senator William Kirchner which make reverse annuity mortgages (a form of home equity conversion) legal in Minnesota. Since that time, the Richfield Bank and Trust Company has completed 20 to 25 reverse annuity mortgages.

There are at least four different types of home equity programs. A Reverse Mortgage is a deferred payment or interest-only loan, generally paid to senior homeowners in monthly installments over a specified period of time with the full amount of principal and accrued interest due at the maturity of the loan or upon the sale of the home. A second form is a Sale/Leaseback agreement in which seniors sell their homes to buyers who immediately lease the home back to the former owners with a lifetime renewal option. In return for selling their homes, seniors receive lifetime occupancy, a downpayment which may be invested to form a "nest egg" for medical

expenses, relief from paying rising property taxes, insurance and maintenance costs, an increase in real income (assuming that the seniors monthly rent is smaller than the buyers monthly mortgage payment) and a long-term income stream via the purchase at time of sale of a deferred annuity. A third form is Property Tax Deferral in which seniors postpone the payment of their annual property taxes until they sell their homes. State government pays the taxes on the seniors behalf with the amount of the accrued interest and deferred taxes acting as a public loan that becomes due upon sale of their homes.

The fourth type of home equity conversion arrangement is a Split Equity contract. The nature of the contract between the two parties is a lien held by a party other than the original homeowner on a portion of the home's equity and future value. This loan becomes due when the senior dies or upon the sale of the property. In return, the senior obtains a guarantee of lifetime, rent free occupancy, and a lifetime annuity payment. This annuity consists of a relatively small cash allotment paid directly to the senior and the in-kind payment of property taxes, fire and casualty insurance and regular maintenance and major repairs on the house.

Nationally, 75% of persons over age 65 own their own homes. Of those, fully 85% have paid off their mortgages. The net home equity of older Americans is greater than \$550 billion. According to Jay Greenberg, net home equity of the frail, non-institutionalized elderly is \$70 billion. To put that in perspective, Greenberg has observed that were those assets freed up in an income stream (say at a rate of 10% per year) the income released would be approximately \$7 billion a year – almost enough to fund total 1979 Medicaid payments to the elderly (\$7.6 billion).

According to Metropolitan Council figures, there are 139,600 older people in the region who live in single family homes. They comprise 74% of the region's total elderly population. If we conservatively estimate the value of an average Twin Cities home to be \$70,000, we can calculate the net worth of senior's housing stock to be \$9.7 billion. Since Metropolitan Council figures show that 90% of the region's seniors own their homes outright, the region's elderly have a net home equity value of \$8.7 billion.

Bruce Jacobs, now of the Brookings Institution, in a 1982 report to the Home Equity Conversion Project analyzed who would benefit from home equity conversion. His analysis yielded several key findings:

- The South has the least potential for reverse annuity mortgages while the West has the most.
- Metropolitan areas in all parts of the country are somewhat advantaged relative to rural communities in terms of their potential for reverse annuity mortgages.

- Low-income individuals and families are relatively advantaged as potential candidates for reverse annuity mortgages. While lower income individuals tend to have less net equity, they have a higher probability of being single and older. Both of these differences would favor the lower income home owner in a reverse annuity mortgage arrangement since they produce lower life expectancy." Jacobs concludes that "on balance, these factors outweigh the net equity disadvantage for many low income households.

Jacobs continued his inquiry by asking what impacts reverse annuity mortgages might have on the disposable incomes of elderly homeowners. For each elderly homeowner, Jacobs calculated the percentage increase in income that would be produced by participation in a reverse annuity mortgage plan producing at least \$600 or \$1200 per year. This analysis showed that:

- In terms of proportionate increases in income, reverse annuity mortgages could have a similar impact in all regions of the country and metropolitan and rural areas. (The smaller net equity in the South for example and in rural areas would be counter-balanced by smaller incomes.)
- Relatively younger elderly couples would be helped the least by the additional income produced by reverse annuity mortgages due to their longer household life expectancies and higher incomes. In contrast, single, elderly, low income homeowners would realize large relative benefits.
- In all regions of the country, a majority of elderly homeowners could net at least \$50 per month and approximately 90% could improve their incomes by a tenth or more. Nationally, one-half of elderly homeowners could increase their incomes by 25% or more. Finally, one quarter of elderly homeowners could enjoy at least a 50% increase in income.
- The potential anti-poverty impacts of reverse annuity mortgages could be substantial. Nationally, the poverty rate for elderly homeowners was determined to be about 14% but rising to 20% for those over 75. After potential reverse annuity mortgage income was added however, substantial decreases in poverty rates were observed. Fully 25% or more of elderly homeowners living below the poverty line would have risen above it. For those over 75, the corresponding figure was 41%. In all cases single homeowners were helped the most while couples were helped to a somewhat lesser extent.

Jacobs concluded that:

"The image of elderly distress (at least with respect to homeowners) that evokes the greatest sympathy and concern in the general public is that of a very old, non-married person (typically a widow) with little to live on. Our analysis suggests that individuals in this group might have the most to gain from a home equity conversion plan."

CONCLUSIONS

I. MINNESOTA'S PUBLIC SYSTEM OF CARING FOR INSTITUTIONALIZED POPULATIONS IS FACING A CRISIS OF SIZEABLE HUMAN AND ECONOMIC PROPORTIONS.

A. The Human Crisis In The State's Welfare Policies Does Not Concern The Quality Of Care In Residential Facilities, But Rather The Quality Of Life.

The quality of care in Minnesota's residential facilities is widely acknowledged to be very good. In nursing homes, for example, a recent study by the Health Care Financing Administration found that Minnesota led the nation in the number of nursing homes which, in the agency's view, could be certified less than once a year. Ninety percent of Minnesota's Medical Assistance participating facilities met the criteria used in the study. (Massachusetts was second to Minnesota with 71 percent of its facilities meeting the same qualifications.) In chemical dependency, Minnesota is an acknowledged national leader, both in the definition of the illness and its treatment. (Minnesotans even coined the term chemical dependency.) People come here from all around the country for treatment. In mental retardation, mental illness and juvenile justice as well, the quality of care is generally considered to be good, even though, from time to time, abuses are uncovered.

Our major conclusion in this study is that too much use is being made of residential facilities in all of the various systems we have examined. This is especially troubling because of the high costs and limited benefits of many of these placements. Residential treatment is appropriate in some cases. But, too often, it has been used indiscriminately. While residential care will continue to be needed it should be used less often. Residential care must become our last option rather than our first option. Too many young people are being placed outside their homes by their parents as well as by the juvenile courts. Out-of-home placements for status offenses are especially troubling, but ultimately no less so than placements which remove the child from the home in instances of parental abuse. How, in such cases, can children not be expected to feel that they are somehow to blame for their family's problems? Moreover, the lack of true success with such placements, combined with considerable evidence that while many roads lead into treatment few lead out, ought to convince us to take a harder look at alternatives.

Much the same situation pertains to the elderly. Pre-admission screening data show that as many as 40 percent of elderly people screened for nursing home admissions could be cared for in other ways. Too many elderly people and their families feel that the nursing home is the only alternative open to them. Too often those in nursing homes are made to feel that their fate is one step short of death. Nursing homes need not be one-way stations. Increasingly, nursing homes should begin to think more in terms of transitional care and providing an array of housing and service options -- many of

which will be outside the physical facility. While some homes are already moving in this direction, much more needs to be done. There is too little emphasis on rehabilitating elderly people to the point where a return to the community is possible. With work, even senility can be reversed.

In the field of chemical dependency, there are disturbing signs that treatment may now involve some people who are pre-abusive at best and non-dependent juveniles at worst. (In fact, there are growing disputes about the nature of dependency altogether.) Much more can and should be done with out-patient therapy. Some hospitals are now beginning to use a mix of in and out-patient treatment. But they are in the minority.

Our system for dealing with the mentally retarded too often denies them the opportunity for full integration into the community - meaning an apartment of their own and gainful employment. Studies have shown that even the most severely retarded can benefit from an assisted life in the community. Too little appears to be done to assist families in caring for their retarded children at home or assuring that the retarded "graduate" from more restrictive settings. It is ironic that there are more retarded people in residential placements today than there were in the 1960's.

Finally, the problems of the mentally ill are a long way from being resolved. A sound, well-coordinated system of community facilities is still not in place around the state. As a result, people often go from state hospitals to the community and back to the state hospital.

So far as we are concerned, there are no villains in these systems, only victims. And the problems are getting worse. In Minnesota today, the institutional bias created by the existing funding sources and exacerbated by odd intergovernmental incentives has created a dual welfare system. In each of the systems which we have examined, Minnesota has one tier of institutions - state hospitals, Intermediate Care Facilities for the Mentally Retarded (ICF-MR's), training schools and nursing homes - and a second tier of community-based residences and in-home supports serving duplicative functions. The majority of public dollars currently serves a small minority of those in need in each system. This situation is frustrating to providers and persons in need as well. Given present financial strains, providers who might want to deinstitutionalize patients cannot find alternative placements with stable or assured funding bases. And providers' best intentions can be thwarted by the incentive to retain people in residential care in order to continue collecting per diem payments. Due to federal cutbacks and shortages of state and county revenues, counties have every incentive to give preference to state hospital placements (which cost them less) over small community alternatives (which cost them more). Ultimately, this is penny-wise and pound-foolish for people's needs and taxpayers' money. And it threatens to undo years of progress towards deinstitutionalization.

Former Minnesota Mental Health Commissioner Ronald Young, M.D., was mindful of this situation when, shortly before his term was up, he delivered the following remarks to the Governor's Forum on Mental Illness at Macalester College in June, 1982. Young stated:

"At the present time, state appropriations earmarked for the same target groups - mentally ill, mentally retarded, and chemically dependent persons...are channeled to the state hospital system and the county mental health system. Much to the credit of county and state hospital leadership, there has been a significant degree of cooperation and mutual planning for these patients and residents, but the basic flaw remains. There are still two systems serving the same population."

"In more affluent times this administrative defect of parallel responsibility was a less crucial problem than now when public funds are less available. Unfortunately, we have now reached a point where patients and residents are beginning to be moved back and forth between the two systems, not because of treatment/rehabilitation needs but because there are strong fiscal incentives to shift financial responsibility to the other system. We are seeing the first indications of a potential migration of people back into institutions because inadequate funding is available at the local level to pay for care outside the state hospital."

Not only are there too many people going into (and remaining in) residential facilities, but research on the question of the quality of life (as distinct from care) has rendered disturbing insights.

In human terms, life in a residential facility is often accompanied by an unhealthy degree of dependence on care givers. Such relationships sap both residents and caregivers of their energy and spirit. What is worse, they often deprive residents of the will to regain their independence. Studies of nursing home residents, for example, clearly show that too much "help" can hurt. (See especially Avorn J. Langer E: Induced disability in nursing home patients: A controlled trial. J Am Geriatric Soc. 1982) In one study, residents were divided into three groups and given varying levels of professional assistance in completing a puzzle. In one group, residents were actively helped by staff. In a second group, residents were left entirely to themselves and told to complete the puzzle. Afterwards, members of each group were asked to assess the degree of difficulty they experienced in completing the puzzle. Residents' responses tended to correlate almost exactly with the extent of professional assistance they had received. Those given the most help felt that the puzzles were most difficult - clearly indicating that some helplessness is learned behavior. The more help people are given, the more many come to feel that they need help in order to function.

Rachel Rustad, administrator of the Stevens Square Nursing Home in Minneapolis, told our committee that after having worked in nursing homes for years, she had many ideas about how one should be run. After she became an administrator, she put many of these ideas into practice - only to see them fail. Re-evaluating many of the traditional ideas helped to give her a new perspective. As she told our committee:

"Gradually, I came to understand that we were teaching people to be sick. The more sick they were, the more attention they received. I began to try to teach the residents about wellness...and encourage them to take more responsibility for their own health. It finally dawned on me that: we were robbing people of their independence with the best of intentions."

Research in the area of mental retardation shows the same impacts on quality of life. An article by the Center on Human Policy at Syracuse University ("The community Imperative", 1979) summarized some of these impacts:

"We know that interaction between institutionalized clients and other people, either other clients or treatment staff, drops substantially in the institutional environment. We know that institutions are more often than not unstimulating environments. We know that institutionalized residents are not likely to be cared for by a few primary caretakers, but by hundreds of different staff over a two or three year period. We know that institutionalized children frequently become apathetic and isolated or overly anxious to gain recognition and attention. Within just a few hours of entering an institution, residents tend to become dramatically less normal, both in appearance and in interaction with others. We know that people who have been institutionalized for long periods of time become more imitative and more conforming. We know, too, that institutions can help infants learn to be non-ambulatory."

The psychological impacts of residential care should also be considered. Entering any such facility for an extended period of time cuts people off from their family, friends, and familiar surroundings and reinforces the idea that if they are in a health care institution, then indeed they must need care. This type of self-fulfilling prophecy can occur even when hospital or nursing home staffs have a strong orientation toward rehabilitation. The longer people remain in a facility, the less likely it is that they will ever return home. In contrast, when people are told that there is a possibility that they can return home, they work harder to make it a reality.

Finally, this state's many well-intentioned efforts to prevent institutional abuse may have had the unintended effect of stifling

life. Too often, overly regulated residential care has sacrificed quality of life to quality of care. Regulations now prescribe what providers must provide. They dictate how many minutes of activities must be engaged in each day, how many meals must be delivered, what residents' diet shall be. Such programmatic mandates may be fine for medical treatment but they are inappropriate when governing the circumstances of everyday living. They prevent, for example, the simple freedoms of everyday life which so many of us take for granted. They impinge on residents' privacy and management of their own time. They often forbid residents fixing their own meals, having a snack, or keeping a microwave or other simple cooking devices in their rooms.

They thwart the efforts of some providers to make residents' lives less rigid and confining. Ultimately, they serve as a constant reminder that residents are on someone else's "turf", that their houses, in the truest sense, are not their homes.

Remaining at home with family and friends allows the person to think of himself as more than just a patient, as a functioning member of a family and society. And, it must be noted, that too often residential care has tended to supplant rather than supplement the vital role of the family. This is extremely ironic because the vast amount of care in each of the systems we have examined is given by family members. While it is true that there are instances in which families are the cause of problems rather than their solution, public systems have done very little to help people take care of their family members. Very few residents are allowed to go home even when the expenditures involved could help the public save the much more expensive costs of residential care. In fact, the way in which public dollars are deployed often forces families against their wills, to place their children in a residential setting. The juvenile justice system, in particular, has had very detrimental effects on families by the extensiveness of its use of out-of-home placement and child welfare rules relating to foster care or adoption of minority children.

While returning home or to an independent life in the community will not be an option for everyone in the systems we have examined, it ought to be encouraged more than it is today. The practice of deinstitutionalization often belies its promise. Too much deinstitutionalization has simply been reinstitutionalization in another setting. With few exceptions, deinstitutionalization has rarely resulted in people being returned to independent functioning. Out-of-home juvenile placements seem only to lead to further serial placements. Release from a state hospital for the mentally ill leads right back to the institutional doors for nearly 50 percent of all discharges. Discharged mentally retarded patients are reinstitutionalized in large ICF-MR's. Once placed in a nursing home, even those elderly people with the potential to recover rarely do. A significant number of the chemically dependent are rehospitalized.

It is time to deter needless institutional admissions from the outset and return those who are able to normal lives outside of residential facilities.

- B. Unless controlled, it is clear that the financial crisis inherent in the costs of these systems will be of 'budget-busting' proportions.

Institutionally-related expenditures are one of the fastest growing portions of the state's budget. There are less costly, more homelike settings available which would be less restrictive to residents and more economical to taxpayers. They should be used.

There can be no doubt that the largest portion of public expenditures related to institutionalization is directed towards the care of the elderly. Persons age 65 or older accounted for nearly 60 percent of all Medical Assistance expenditures but represented only 20 percent of the recipients in fiscal year 1982. Medical Assistance payments for persons in long-term care facilities increased twice as fast as the Medical Consumer Price Index between 1976 and 1981. Ways must be found to deal with these costs now, because the future growth of the elderly population will be substantial. Nationally, between the years of 1980 and 2030, the overall U.S. population will grow by about 40 percent, but those over 85 are expected to increase three-fold. Minnesota's elderly population is expected to increase by 24.3 percent between 1970 and 2000, with those over 85 (who are prime candidates for nursing home care) expected to increase by 48.3 percent.

There will be no federal "bail-out" for these costs. The federal government will have a hard time simply maintaining what it is doing today. (In fact, the Social Security trust fund still has problems and the Medicare trust fund, according to predictions, will be financially exhausted within a few years.) States like Minnesota are already the biggest payers for long term care services, particularly for nursing home care. States pay about 50 percent of nursing home costs and seem incapable of shouldering much more of the burden.

So unless Minnesota begins soon to develop a long range strategy to manage such cost increases in the future, these expenditures threaten to overwhelm our ability to pay for them.

There are other disturbing things about these high costs aside from their future affordability. In particular, we find it alarming that in Minnesota, in 1981, a total of \$185 million public and private sector dollars were spent for institutional placements of children. That \$185 million is roughly equivalent to about one-fifth of the state school aids spent to educate the children in Minnesota, even though the number of children in placement is only about two percent of the total number of state school children. To have spent so much, with so little result, when other populations (AFDC, others) are suffering financially, seems to us to call for a redefinition of state priorities.

Efforts must be made to control these costs. In the pages which follow, we present our program for action. It is comprised of five basic steps. They are:

- 1) State and local governments should take steps to assure that alternatives to residential care are vigorously pursued prior to admission into any treatment facility.
- 2) Payment for the housing portion of care should be separated from payment for the service portion of care.
- 3) Public funding should follow people's choices in order to give consumers leverage over the systems that serve them and place residential and non-residential providers in competition with each other.
- 4) To give people more choices about the physical environment in which they live, and the care program which is provided them, some public regulations must be selectively removed.
- 5) Reforms are needed in the way that Minnesota pays for residential care. Specifically, government should begin to move towards prospective reimbursement, provide bonuses to providers based on their performance and give consumers incentives to use high-quality, low cost "preferred providers".
- 6) Private financial mechanisms should be developed to assist the elderly in meeting their financial obligations as well as to defray some public costs.

II. STATE AND LOCAL GOVERNMENT SHOULD TAKE STEPS TO ASSURE THAT ALTERNATIVES TO RESIDENTIAL CARE ARE VIGOROUSLY PURSUED PRIOR TO ADMISSION INTO ANY TREATMENT FACILITY.

In every system, steps should be taken to assure that alternatives to residential care are vigorously pursued prior to admission into any treatment facility. One vehicle to accomplish that is preadmission screening.

The function of screening, as we see it, is to make several key determinations. First, screening must provide consumers a balanced professional opinion on their health status, assessing whether, given the person's condition or functional limitations, continued residence in their home is feasible. Such decisions should consider the amount of available informal support from informal caregivers such as spouse, friends, neighbors. The assessment team should render its opinions on these questions to the individual along with its prognosis of how long residential treatment (if indicated) should be expected to last and what the preferred outcomes of that treatment would be. The decision concerning whether to utilize such treatment facilities, however, should retrain squarely in the individual's hands.

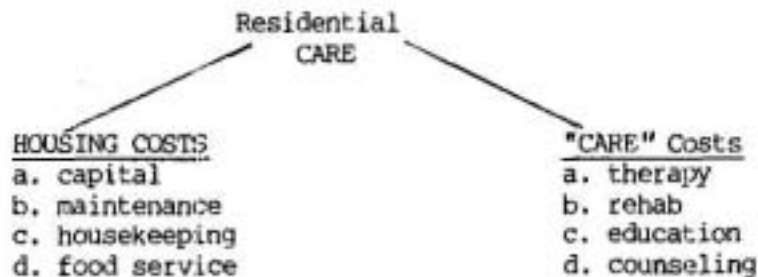
Whether people elect to receive home care or residential care outside their homes, the assessment team should be able to provide information on programs, providers and options.

But screening should not simply be a one-time occurrence. We believe that there are many persons currently living in residential facilities at public expense who could be more humanely and cost-effectively cared for in other settings. Some kind of ongoing screening mechanism is needed to determine just how many such persons there are in each system, and provide them with other alternatives.

III. THE "PROBLEM" IN EACH OF THESE SYSTEMS IS THAT PEOPLE CAN ONLY RECEIVE "SERVICE" IF THEY LIVE IN A RESIDENTIAL FACILITY. BUT THAT PROBLEM COULD BE ALLEVIATED IF PAYMENT FOR THE HOUSING FUNCTION WERE SEPARATED FROM PAYMENT FOR THE CARE FUNCTION.

A. Entirely new housing and service options could be made available to people if, in every system, payment for the housing function were separated from payment for the care function.

"Service" in existing residential arrangements can be thought of as consisting of two parts: housing and care. Both parts of service are packaged together in a "comprehensive" residential facility.



But this need not be the case. And particularly in the acute care system there is a growing trend towards "unbundling services" from their hospital base and delivering them elsewhere. Hospitals are rapidly moving away from bricks and mortar towards community-based service delivery. Home dialysis is a growing trend. Intravenous treatment can now be safely delivered at home. Maternity stays in hospitals can often be cut in half by sending the mother and newborn home with visits from a nurse.

Abbott Northwestern Hospital, for example, has built a hotel within its campus in which to house patients in need of tests prior to admission and the relatives of patients already admitted. Over time, the organization is considering using the facility to house patients discharged from the hospital after stabilizing their condition.

As the federal government begins to reimburse on the basis of diagnostically-related groups, the practice of separating the hotel function from the care function will increase. Hospitals will get only one payment: for a given diagnosis, prompting them to discharge people earlier. (The longer an individual is hospitalized, the more likely the hospital will be to exceed the government's lump sum payment.) Particularly for the elderly, hospitals will need other places to care for these people and may begin to negotiate with nursing homes or even hotels for space if care cannot be provided at home.

We believe that the choices available to populations who now use residential facilities would be expanded considerably if, in every case, the payment for the housing function could be separated from payment for the service function. If this were done, people could exercise choices both about where they live and from whom they received the care service. And, if public dollars for housing and care were allowed to follow peoples' choices, then people could choose whether or not to remain in an institution or residential facility or live elsewhere. Likewise, they could decide to live outside the facility but continue to receive its services, continue to live in the facility but receive services from another vendor, or continue to live in the same facility and receive services there as well.

Separating the housing function from the care function would be beneficial for three reasons. First, it would address several existing problems. ' Second, it would likely create new entrepreneurial housing and service opportunities for providers. Third, it opens the door for new equity and ownership possibilities for residents. Let's discuss each of these advantages in order.

Helps Solve Existing Problems

there are several problems with existing arrangements which combine payment for housing with payment for "care".

First, building owners and operators of these facilities receive such preferential treatment under current tax laws (relating to capital depreciation) that it encourages real estate speculation and a fairly rapid turnover of facility ownership. Such instability is not healthy either from the perspective of residents or the public interest since a by-product of such sale and resale arrangements is that facility costs go up substantially.

Second, paying for housing and care from the same provider places both the residents and government in the position of dealing with a monopoly supplier. Both the housing service and the care service must be purchased from the same provider since it is often too disruptive (MR, others) or inadvisable (many elderly, especially frail elderly) to physically move the residents from one facility to another. Due to this situation, residential providers can literally hold residents "hostage" unless government accedes to their demands.

(The most recent examples of this were the actions of several suburban nursing home establishments which threatened to move residents to a "welfare ward" or become private pay facilities unless changes were made in public reimbursement.)

Third, paying for housing and care from the same provider makes it hard to compare costs from one residential facility to another and particularly hard to compare them with the costs of home care and other non-residential care options. This is especially troubling because in many residential facilities, no one can be entirely sure what is being purchased. Nor can facility costs (rent, laundry, food service, janitorial and maintenance services) be separated from programmatic costs (therapy, rehabilitation, education, recreation, counseling).

The benefits of paying for housing and care separately are numerous. Separating payment for housing and care improves the potential for consumers and the government to know just what they are buying from a given facility. Second, it affords a much better way to examine and compare similar components of facilities costs. Third, it provides the basis to compare the costs of residential and non-residential care to determine the point at which the latter may no longer be cost-effective.

Finally, it could put an end to the monopoly supplier situation by allowing residents to stay, physically, where they are, yet gain service plans offered by competing providers.

Creates New Opportunities for Service Entrepreneurs

Separating the payment for housing from that of care may encourage a variety of new providers to enter the housing and care markets. In fact, under such an arrangement, housing and care may even become separate markets.

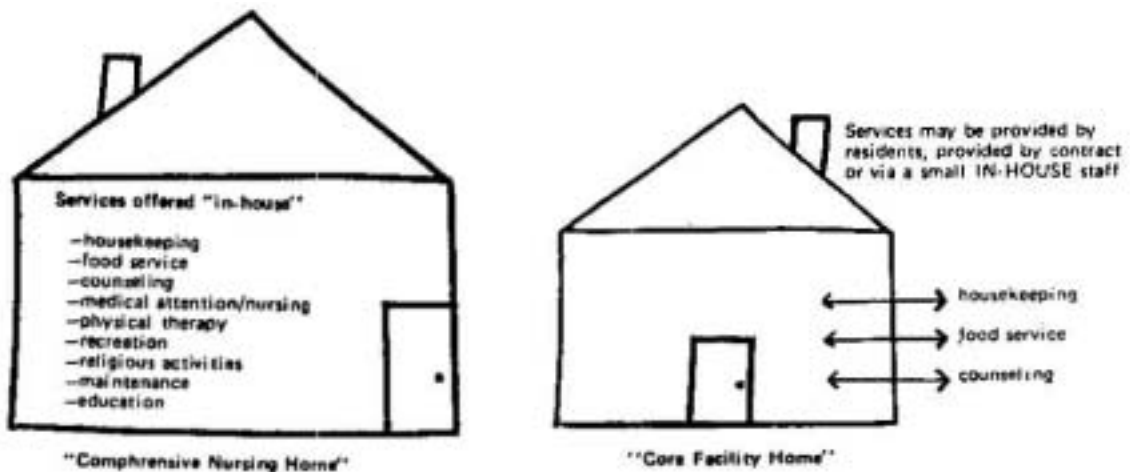
We could envision some vendors specializing in housing and residential services with other groups or agencies providing needed services. Many hospitals, nursing homes and other residential facilities could take advantage of this opportunity to unbundle services and deliver them in the community. Both New York's Nursing Homes Without Walls Program and St. Paul's Saint Anthony Park Block Nursing Program are illustrative of the type of service-related entrepreneurs which might prosper.

New Ownership Possibilities

Separating the reimbursement for housing from treatment costs should increase home care and day care incentives to the elderly and families of the mentally retarded. But, particularly for these populations it should also provide opportunities to explore new cooperative ownership arrangements in which residents own a share in the facility. Existing facilities might be remodeled into congregate living arrangements or new cooperative housing options could be

created through conversion of existing single family homes. It is even conceivable that consumers or their surrogates would contract with providers to have services brought in to the home when needed or that, alternatively, residents could go to where the service is being delivered in the community.

This new model would turn a present day nursing home or ICF-MR on its head. Instead of having the facility be owned by management, the new model envisions ownership in the hands of residents. Instead of having the nursing home be a "comprehensive service facility," the new model would minimize the amount of 24-hour staff and contract out for needed services. Service would be delivered when residents wanted it and in the amount they requested instead of at professionals' convenience and at levels which they deem appropriate. Rather than having a monopoly supplier of service, there could be many providers, ... in competition if desired. Residents could be as dependent or independent as they wish, allowing them for example, to cook their own meals or contract out for that service.



Today, there are no nursing homes which allow the elderly to "buy" their rooms in an effort to preserve any form of equity in their "homes." Only a very few metro area housing arrangements make arrangements for the elderly to have some ongoing equity. (e.g. Ebenezer's 7500 York development.)

But benefits from this situation can be readily imagined. People could buy and sell their equity in nursing home rooms. Government would be freed from having to pay both the housing and care components of elderly services. In nursing homes today the federal government is paying Medicaid bills that include housing as well as medical services. By having cooperatively owned nursing homes or congregate living units, Medicaid funds could be used to pay only for medical-social services instead of housing-medical services.

While ownership options would not apply to juveniles, the mentally ill or the chemically dependent, separating payment for housing from care might still expand rental opportunities if the individual could not be treated successfully at home or on an out-patient basis.

For all populations, the possibility to rent or own a space in an existing facility or, better still, converted housing, could greatly contribute to residents' "quality of life." There would be a much better sense than there is today that the space they occupy is truly theirs, and that in that space, they are free and their privacy complete. Residential treatment would become more homelike because people would be making their homes there. Providers would have more of a feeling upon entering the building that they were entering a residence, not simply a place of employment and that in doing so they were setting foot on "residents' turf."

- B. If the payment for housing and care were separated, people would be given access to a range of medical, social, professional, para-professional, and volunteer providers.

There is a growing debate over the questions of who shall doctor and over the merits of professional licensure.

One hundred years ago our most life-threatening health problems came from infectious diseases like tuberculosis, smallpox, diphtheria, and typhoid. Back then the onslaught of these diseases was the cause of death for one out of every three men.

In response, physicians were taught to wait for recognizable symptoms of the disease, then attempt to cure it. Over time powerful new vaccines and antibiotics helped to treat some infectious diseases and eliminate others.

Today, however, infectious diseases are no longer the principal health problem in the U.S. Chronic diseases have assumed that status. As a percentage of all disease, chronic disorders have increased to 80 percent since the 1930's,

Chronic diseases require different kinds of treatment. And they may demand alternatives to traditional medical practices and conventional physicians.

These trends are raising many new questions. Medical practice laws, like teachers certification, are increasingly under scrutiny. Tough questions are being raised. Do medical practice laws protect a patient's health or a profession's monopoly? Can we cut costs by allowing more non-physician practitioners into the system? When

must physicians be consulted and when is it appropriate to depend on nurses, paramedical personnel and others? Does the formal care provided by professionals tend to supplement or supplant the informal care provided by families and friends?

These are controversial questions and they are coming at a difficult time for the physician community. Both the United States and Minnesota have surpluses of physicians. There is growing competition among physicians and between physicians and hospitals. And there are more constraints on the use of public resources. Some physicians have embraced the option of using alternative medical personnel. Nurses and others can deal with less acute cases and thus make more appropriate use of medical personnel. Increasingly, this idea is taking hold in the area of obstetrics. But there is a lot of resistance to the idea. When the Metropolitan Health Planning Board released its report entitled, "Prescription for Change: Balancing Competitive, Community and Regulatory Forces in Twin Cities Health Care," and asked for community comment, virtually the entire hearing was turned into a referendum on this issue.

This debate is particularly relevant for the majority of the populations involved in our study. The problems of the chemically dependent, the mentally ill, the mentally retarded and many elderly people, are often chronic or functional in nature. Since such problems are not inherently medical in nature a variety of responses seems appropriate.

Some of these responses necessarily will be innovative ways to have professionals deliver care. Much more and much better use of nursing personnel seems just around the corner. The Saint Anthony Park Block Nurse Program is an excellent example of how nurses can be used to deliver home care to elderly residents. Some day such "nursing pools" will be commonplace. Many nurses withdraw temporarily from practicing to have children. They require more flexible working hours in order to return to work. Nursing pools could provide that and help the community make use of a latently underutilized resource.

Other responses will likely use para-professionals or volunteers to provide service. Hennepin County has developed a Service Coordination Model which leverages county dollars by funding community care organizations that provide informal care givers (skill banks). Some hospitals and home care organizations train family members to administer certain forms of care. Other innovative arrangements pair elderly people with college students. The students receive free room and board in return for house and lawn maintenance and the performance of other relatively simple chores.

IV. LET PUBLIC FUNDING FOLLOW PEOPLE'S CHOICES IN ORDER TO GIVE CONSUMERS
LEVERAGE OVER THE SYSTEMS THAT SERVE THEM AND PLACE RESIDENTIAL AND NON-
RESIDENTIAL FACILITIES IN COMPETITION WITH EACH OTHER.

Government should make the decisions about how much money should be made available to meet the needs of a given individual. Individuals themselves (or their surrogates or guardians) should make the ultimate decisions about how such moneys are to be spent, including the decision about which provider to utilize and where they will be housed during "treatment." (If payment for housing were separated from payment for care, consumers would face choices in each of these areas.) The appropriate role of professionals in this equation is to inform consumers of the housing and service options available to them.

Where individuals lack the capacity to choose on their own behalf the next logical choice is the family – not government. Where family is not available guardians or conservators should play that role.

There is evidence that this model can also be cost-effective. If consumers are asked to share part of the cost of care (e.g. housing) they will have an incentive to keep costs down. If public dollars follow their choices, providers will have to compete for their favor by developing service packages. Consumers will select those packages offering the most care for the least cost.

Such competition would have an especially helpful impact on the systems we have discussed: in this report. In each of these systems public reimbursement has created two systems, – one highly institutional/residential with formal provision of services by professionals, the other, much more community based with a different mix of formal and informal supports. The first system receives the majority of public dollars yet serves a small minority of those in need. The second system receives a minority of the money and serves more people.

As the systems now stand the two systems do not compete for scarce public resources. Our recommendations would force them to do just that – squeezing out wasteful excess capacity in the process.

Under the new system we envision, residential care will be used more sparingly – indeed our recommendation about separating payment of housing from payment for care would seem to guarantee that. Home care and non-residential forms of care would be used more as individuals seek to minimize or eliminate their share of the housing costs.

Given the differences among and within populations, people in different circumstances would face different choices. For the sake of simplicity we can delineate three different population subgroups within each of the disabled populations we have studied. First, there are individuals who are likely candidates for residential care and may in fact be about to enter a facility. Second, there are

people who already live in residential facilities and could live elsewhere – some independently with a minimum of help – others with somewhat more help. Third, there are those who live in residential facilities and will always need to live in such intensive care situations.

For those who are candidates for residential care, separating payment for housing from care would provide a real choice between home care, other forms of non-residential care and residential care. Pre-admission screening can increase people's awareness of their options and actively encourage the substitution of less intensive alternatives for residential care. And substituting the one for the other makes good sense from the perspective of the public treasury. According to Don Richardson of the Minnesota Department of Public Welfare, more than 1,000 candidates for nursing homes have already been diverted to home care. In 1983 this produced savings of \$5 million. Richardson believes that figure could grow to as much as \$12 million in the foreseeable future.

For those who already live in residential facilities but could live independently with some help or in a less intensive residential setting, these ideas hold the promise of a new array of housing and service choices. Home care with a visiting nurse is an option. Life in a rehabilitated single family home with a small staff and service contracted in is another. Both could provide care in a more homelike setting at substantial public savings.

Finally, for those unable to be discharged from an intensive residential facility, these ideas could still provide a choice of different service providers. This could be achieved by converting ownership of such facilities to residents and allowing them to contract for service by having smaller residence staffs geared to provide a minimum of care and housekeeping duties and then encouraging competitive bidding among service providers to provide the majority of care. If government distinguishes between housing and care, lets separate contracts for the real estate maintenance portion and contracts for care, the same result will have been achieved. And all of these options allow for potentially better, more cost effective care without physically moving the residents.

V. TO GIVE PEOPLE MORE CHOICES ABOUT THE PHYSICAL environment IN WHICH THEY LIVE, AND THE CARE PROGRAM WHICH IS PROVIDED THEM, SOME PUBLIC REGULATIONS MUST BE SELECTIVELY REMOVED.

Another consequence of separating reimbursement for housing from service is movement towards limiting the extensiveness of regulations currently affecting physical facilities. If reimbursement for housing follows people's choices of where to live, some of those choices may conflict: with current regulations specifying particular design or architectural attributes of "appropriate" residential facilities. Likewise, if the elderly or the mentally retarded begin to demand equity shares in group homes or residential facilities, they may also seek alterations in existing regulatory design codes affecting their living quarters.

Moreover, if people who are capable of living independently of residential facilities are allowed to leave those facilities and given access to "unregulated" living quarters, providers will demand either that the Legislature regulate the kinds of housing choices which people may exercise or that physical regulations on their facilities also be relaxed.

Inevitably, such demands will force a public re-examination of the intent, functions and effects of many existing regulations. We believe that such a re-examination is long overdue.

There is a predictable process by which many regulations are enacted. The press and media display a problem. Politicians respond with a law to do something about it. Finally, public regulations appear. Over time, as such regulations increase, the cost to providers to implement them escalates, resulting in "hidden costs" within the system. These costs are expensive to providers and taxpayers but are often lucrative to contractors and labor. Some providers especially smaller operators, can no longer afford to comply with the costs of making required design changes and go out of business, often leaving only larger facilities in place. As a result, people are deprived of valid choices. While the design codes add to the level of care provided to residents, it is debatable whether they ultimately add much to quality of care. (In fact, to the extent that the size or scale of the facility affects quality of care, the end result may be negative)

Regulations can, in some instances be demeaning to the very people whom they are trying to "protect". Sharon Stuart, for example, a staff member of the Association of Residences for the Retarded in Minnesota (ARM) told our committee of a new task force which has been formed to examine current rules and regulations in order to understand the extent to which they impinge on clients' independence. "Even though these rules were formed with the best of intentions," Stuart said, "they are degrading."

The same kind of arguments can be marshaled against many rules and regulations which prescribe who shall deliver care. Lyle Wray, the court appointed monitor for the Welsch versus Levine Consent Decree told our committee of his experiences as an employee of a state hospital. Rules concerning client/staff ratios, he said, often are used to perpetuate employment for state hospital workers. Given the high staff ratio of state employees in such facilities, Wray said, the retarded are not even allowed to do their own laundry. Such practices deprive residents of the opportunity to learn skills which they would need to live independently. Without such skills, the possibility of being deinstitutionalized is reduced.

No one would suggest that the state deregulate these systems entirely. The potential for abuse in centralized or decentralized systems will always be with us. But re-examining existing policies

and encouraging thoughtful, deliberative deregulation would be especially helpful at this time. A deregulated system is not the same as an unregulated one. Some rules are vital and should be maintained. But the state needs to think more carefully about which ones merit that status.

VI. REFORMS ARE NEEDED IN THE WAY THAT MINNESOTA PAYS FOR RESIDENTIAL CARE. GOVERNMENT SHOULD MOVE AWAY FROM OPEN-ENDED REIMBURSEMENT SYSTEMS AND MOVE TOWARD PROSPECTIVE REIMBURSEMENT.

- A. State and county governments should set limits on the amount they will pay for care and move toward prospective reimbursement.

Public reimbursement should be linked to peoples' functional condition rather than to particular levels of residential care. And increasingly, rather than open-ended fee for service funding systems, the state should move in the direction of prospective reimbursement.

Prospective reimbursement is already in place in acute care with the implementation this year of the federal government's new payment system on the basis of diagnostically related groups (DRGs). With DRGs, the federal government agrees to pay a set amount per diagnosis. While there are some problems with this system (it fails, for example, to be age or severity-adjusted and does not account for the presence of multiple diagnoses), the principle behind it is sound. Prospective reimbursement puts providers on a budget and puts them in the position of managing care. When that is true the real issue becomes style of medical practice, and there is ample evidence that quality of care can be provided without 'Cadillac' medicine.

Minnesota began to move in the direction of prospective reimbursement for its nursing home population last year with the passage of a bill sponsored by Rep. John Clawson and Sen. Linda Berglin. We urge an adaptation of the prospective reimbursement principle be used across advisability groups. But instead of linking reimbursement to diagnoses, which are medical problems, we urge that it be tied to functionally related groups (FRGs) because the problems plaguing these populations are chronic and functional, not medical in nature. In order to overcome the difficulties evidenced by the DRG system, such FRGs should be age and severity-adjusted and capable of dealing with multiple diagnoses. Minnesota's Medicaid Demonstration Project is already beginning to create a formula which can be adjusted to address these concerns across populations.

There are two basic ways of determining how much a given FRG would be worth. One way is for government to fix the price itself. Another is to allow the price to be determined in the marketplace. While we believe that government should be prepared to pay more on behalf of those who are most severely disabled, we feel the answer to the question, "How much more?" should be settled by tying the reimbursement level to the prevailing community norm for that service.

FRGs then should provide the base rate of reimbursement. But beyond that, financial incentives need to be created and tied to providers' performance.

- B. State and county governments should begin to pay providers on the basis of their performance.

Across all publicly subsidized human service systems today, there is a growing negative reaction to reimbursement systems which guarantee service providers an income stream in return for nebulous results. The public, and increasingly some legislators no longer believe that "there is no way to measure performance" in human services delivery. As a result, particularly in the field of education, there is a growing demand for accountability -- more tests of students' performance, teacher testing, merit pay, etc.

It is time to apply the notion of outcome-based reimbursement to the care of institutionalized populations.

We have already discussed the concept of outcome-based reimbursement as developed by Rosalie Kane. This system would seem to fit perfectly with our earlier recommendations. The primary function of pre-admission screening would be to establish a prognosis and furnish the individual with information regarding potential providers. Public reimbursement based on the individual's functional condition or FRG would then follow the individual's choice of provider. Providers would compete to offer people the best service possible. Once people selected a provider, public reimbursement would follow their choice. Beyond the base rate of the FRG, providers would be at risk depending upon their ability to satisfy the conditions of the patient's prognosis. Superior performance would lead to financial gain. Inferior performance to financial loss. Thus, reimbursement is partly determined by patients' functional status and partially by providers' performance. At the end of each reimbursement period, the individual would be re-evaluated and a new prognosis established. Such periodic assessments could also serve the purpose of re-evaluating the need for continued residential treatment.

During each reimbursement period, all providers would receive the same rate of remuneration (i.e., the pertinent FRG rate). At the end of each period, when the individual is reassessed, providers receive adjustments based on the individual's progress. If progress is not consistent with the prognosis, reimbursement is adjusted downward. Providers might get bonuses for helping to maintain a stable condition of good health. (Or stated differently, for avoiding the extra costs which would be occasioned by a negative turn in the person's condition.) The more successful providers are at helping people stay out of a higher level of residential care, the larger the bonus they might earn. Another option would be to give providers bonuses for rehabilitating people to the point where the level of service could be reduced or they can return home.

A base reimbursement rate based on peoples' condition combined with performance incentives should counteract the potentially fraudulent FRG-creep abuse. (In the acute care system, some people argue that providers have incentives to escalate their diagnoses to more complicated, and hence, more lucrative maladies.) A base rate that is adjusted by providers performance towards helping people become less dependent on the formal care provision would seem to reduce, though not entirely eliminate the potential for this kind of abuse.

How could this concept be applied across systems?

Elderly - give providers bonuses for helping the elderly to stay out of nursing homes and hospitals or rehabilitating them to the point where they could be discharged from a facility.

Mentally Retarded - give providers bonuses for training and educating the retarded to the point where they could live semi-independently, take on a job or receive service in a daily activity center (DAC).

Mentally Ill - give providers bonuses if they can successfully prevent re-hospitalization.

Chemically Dependent - Provide bonuses to providers which reduce the use of in-patient facilities and which reduce recidivism.

Juvenile Justice - Give bonuses to providers which demonstrate a lower recidivism rate and law abiding behavior in juveniles after treatment. Give bonuses to case workers who find ways to utilize less intrusive, lower cost forms of incapacitation.

- C. Individuals should receive incentives to use high quality, low cost, preferred providers, regardless of whether their care is provided at public or private expense.

The substantial differences in the cost of various forms of residential treatment in each system represent a major opportunity to allow people to receive care in more homelike and cost-effective surroundings. Whether people's care is ultimately paid for through public or private means, purchasers should pay attention to the substantial differences in treatment costs which we have uncovered in this study.

Although some people may always need residential treatment of some sort, it does not always follow that these services must be provided in highly intensive, costly settings. The opportunity to separate housing from care could open up lots of innovative new practice styles. Ira Schwartz of the Hubert H. Humphrey Institute of Public Affairs has documented (only half facetiously,) that we could confine some juvenile offenders in some of the region's fancier hotels and still save public dollars.

Providers could be designated as 'preferred' on the basis of price but also on the basis of outcomes as well. Given preceding recommendations on outcome-based reimbursement, gauging provider performance should be an easier and more readily accessible task.

Purchasers of health care, whether private insurers, the public sector or individuals all should have ample cause to begin developing "preferred relationships" with some providers. Doing so would go a long way to ease the questions of overcapacity plaguing many of these systems.

VII. PRIVATE FINANCIAL MECHANISMS SHOULD BE DEVELOPED TO ASSIST THE ELDERLY IN MEETING THEIR FINANCIAL OBLIGATIONS AS WELL AS TO DEFRAY SOME PUBLIC COSTS.

Public programs which pay for the care of the elderly are the largest portion of institutional expenditures. Both Medicare and Medicaid have been plagued with fiscal pressures and no massive infusions of federal spending are now in sight. As a result the intensity of the search for private mechanisms to shore up public systems which care for the elderly is increasing. Even the federal government, through its tax codes is now learning heavily on individuals to save money for retirement through IRA's;.

At the state level, Minnesota already spends millions of dollars per year for long term care for its elderly population and its capacity to spend more is doubtful. At the same time, statistics tell us that Minnesota has not yet even begun to see the major demographic bulge of elderly people with which it will be confronted in the future. Common sense dictates that if public dollars continue to be spent as they are today, and no infusion of private dollars is added, Minnesota and its elderly population could be in for real trouble.

Minnesota must begin now to develop a strategy for dealing with long-term care costs. Such a strategy must recognize both the limits of peoples' personal resources as well as the limits of the public purse. A new synthesis of public and private effort will be required.

From our perspective, the rudiments of this long range strategy should concentrate on the following components:

1. Efforts should be made to prevent unnecessary institutionalization, through pre-admission screening and other means.
2. Elderly people in residential facilities who are capable of living on their own, should be provided with the means and opportunity to do so.
3. Stronger efforts should be made to rehabilitate elderly people to the point where a return to independent living is possible.

4. While each of the three strategies above is a useful contribution to an overall strategy, its major focus should be on the pre-elderly and developing private mechanisms to assist their continued financial independence in their later years. Specifically, mechanisms will be needed that protect elderly people from catastrophic long-term care costs and which can provide a steady income stream during their retirement years.
5. If new private financial tools such as long term care insurance and home equity conversion can be successfully developed, people will be protected from becoming poor as a result of chronic illness and disability. And the public sector, spared the additional burden of these costs, should be able to concentrate its efforts on providing for the financial and service needs of the poor.

While it is important to make progress in all of these areas, there is an immediate need to begin developing a market for long-term care insurance. The absence of such coverage is the single largest contributor to elderly peoples' impoverishment and increases in public costs. One company in the forefront of such insurance is Fireman's Fund American Life Insurance in San Rafael, California. It began offering long term care insurance in California in 1974 and today offers such coverage in all of the Pacific Coast states as well as Arizona, Florida, Texas, Nevada and Idaho. The coverage provides \$60 per day for a stay in a skilled nursing facility for up to four years. Premiums range from \$1,100 a year if purchased at age 78 to \$450 per year if bought at age 65. According to Robert Phillips, a company spokesman, the policy covered 12,500 people in 1983.

But the prognosis for private insurers getting into this business is not necessarily promising. A two-year, soon-to-be-released study of such insurance wasn't encouraging, according to Arthur Lifson, assistant vice president of the Equitable Life Assurance Society of the United States, New York, and chairman of a Health Insurance Association of America task force on long term care.

The problem, according to Lifson, is that "consumers perceived our major competition to be Medicaid, a program regarded as free and a right of the middle-class." Because Medicaid is viewed as providing acceptable nursing home care for older Americans, Lifson thinks the only people who would buy long-term care insurance will be those citizens with high assets.

Several possible approaches could overcome this problem. One approach would be to encourage private employers to provide long term care insurance for their employees. A second approach would be to find more ways to help individuals approaching retirement age purchase such policies themselves. This might be accomplished either by innovative life insurance arrangements which could be converted to long-term care coverage later in life or reverse annuity mortgages where part of the annuity would be spent to purchase such coverage.

In the short term, however, the best way to stimulate a market for long term care insurance would be to have the public sector pay for private coverage for eligible recipients prior to the point at which they actually require care. Paying the premiums for such coverage at the "front-end" would make much more sense economically than paying for care when it is actually required, as is the case today. The public sector should set upper limits on the premiums which it will pay and let consumers shop for coverage. Providers would then compete, on the basis of benefit packages, for this sizeable market.

Beyond stimulating a market for long term care insurance, efforts should be made to increase the income or net assets of the elderly. Jay Greenberg of Brandeis University believes that there are at least four ways to do this. One way is through private pensions. Greenberg has suggested that there "ought to be ways to take a life insurance benefit and turn it into a pension annuity." A second option would be to redesign Social Security. A third option would be to continue to push private savings programs such as Independent Retirement Accounts. Some people have even suggested that the government encourage the development of IRA's, specifically dedicated to long-term care, so that people are encouraged to save money for future medical and functional needs. The fourth option is home equity conversion.

While all of these options are potentially promising, the most exciting prospect, we believe, is home equity conversion. And, as our findings show, the Twin Cities elderly population would clearly have advantages under such an arrangement because they are more likely than the national population to own their homes outright. With appropriate safeguards, people could use the equity in their houses to finance their health care costs in their old age. According to Ken Scholen, executive director of the National Center for Home Equity Conversion in Madison, Wisconsin, "people are more willing to use this money for health care than for anything else." National estimates indicate that 46% of the elderly are homeowners and one-third could pay for long term care through equity conversion.

There are several new home-equity related developments on the national scene. The Bureau of Maine's Elderly is developing a variety of home equity conversion models for implementation and the Maine Legislature is considering a proposal by the state's housing authority (MSHA) to subsidize reverse mortgages. The nation's top official advisory commission on aging policy unanimously endorsed two major legislative proposals on home equity conversion. On May 17, 1983, the Federal Council on Aging (FCA) formally recommended passage of an FHA reverse mortgage insurance demonstration program, and Internal Revenue Code amendments clarifying the tax implications of sale-leaseback arrangements.

But the most significant event thus far, has been the introduction of a new legislative proposal now pending before Congress called the "Home Equity Conversion Act". The bill, sponsored by Sen. Arlen Specter, R-Pa. opens the door for homeowners to pull tax-free dollars

from their homes, without moving or taking out second mortgages. The measure would remove technical problems in the federal tax code which prevent sale-leaseback arrangements and thus, encourage private investors to acquire single-family homes on advantageous terms in order to rent the property back to the former owners.

Should the proposal pass, (and it is likely to do so,) it might work this way. Let's suppose an elderly couple own their home free and clear but have little retirement income coming in. They would like to travel more and enjoy a higher standard of living. But rising prices, inflation and steadily increasing property taxes limit those possibilities. The couple realize that the equity money needed to change their lifestyle is frozen in their home but see no way to make that liquid. They do not want to sell their home with its wealth of memories nor is a second mortgage appealing.

Under Specter's proposal, this couple could sell their home to outside investors who would then lease it back to them. The couple could sell for an all-cash price, or more likely, finance the sale themselves using an installment contract. That would entail a modest cash downpayment by the purchasers - say 10 percent - and a 10 or 15 year note held by the sellers carrying a mutually acceptable, fixed interest rate, such as 11 percent.

The couple would give up the legal title to the property, but they would get an iron-clad lease guaranteeing them occupancy of the home for life, if they chose, on advantageous rental terms. The couple would escape paying the high property taxes on the property and would get a sizeable monthly check (including principal and interest) for income. In return, the couple would send a rental payment (substantially less than the installment check) to the investors.

The couple could also consider purchasing an interest-bearing annuity that would mature after the mortgage payment flow stopped, thereby guaranteeing them cash to pay the rent indefinitely.

For their part, the investors would receive a sizable discount on the sale price of the home - perhaps 20 percent off - plus below market rate financing. They'd also get responsible stable tenants and substantial annual federal tax writeoffs for depreciation, interest and other costs.

According to figures provided by the National Center for Home Equity Conversion in Madison, Wisconsin, a sale-leaseback arrangement of this type on a house sold for \$120,000 would render a monthly mortgage payment to an elderly couple of \$1,031. A \$90,000 home would garner \$773 a month. And a \$60,000 home would net \$511 per month.

Jack Gutentag, who holds the chair in banking at the Wharton School, University of Pennsylvania, has offered the most compelling case for the use of home equity conversion. (See Gutentag's "Creating New Financial Instruments for the Aged", 1975, New York University.) Gutentag, one of the original pioneers in this area has stated:

"The unique appeal of home equity conversion as a means of improving the economic status of the aged is that they require no 01: minimal transfer payments. In effect, the aged who own their own homes are enabled to help themselves without significant cost to taxpayers. Even if there is a cost in creating the required institutional structure or an opportunity cost in the provision of loanable funds by Government, it would be a small fraction of the benefit accruing to those who take advantage of the plan."

Gutentag says that such financial instruments widen the freedom of choice to the elderly by providing a new method of dissaving. (Dissaving is the process whereby one's savings are used to meet present expenses.) "Existing methods," he argues, are generally unsatisfactory because:

- Elderly people frequently have no substantial assets to liquidate other than their home,
- It is difficult for the elderly to obtain loans. Loans which are obtained cover only a part of their equity, and the terms of such loans will generally be "shorter than the borrowers' expected life expectancy, thus obliging the elderly person to buy back their equity in their remaining years."
- Undermaintenance of elderly people's homes is their most widely employed method of dissaving, but it creates problems by allowing the value of their homes to deteriorate over time.

With financial instruments as complicated as sale-leaseback agreements, reverse annuity mortgages, split equity arrangements and the like, there will be a major need for consumer safeguards. Maurice Weinrobe, of Clark University has written an excellent paper on this topic. ("Consumer Safeguards for Instruments Unlocking Home Equity for the Elderly," March, 1981) While acknowledging the need for further thinking about consumer protection, it should not preclude our community from thinking further about possible applications of these ideas.

RECOMMENDATIONS

I. STATE AND LOCAL GOVERNMENT SHOULD TAKE STEPS TO ASSURE THAT ALTERNATIVES TO RESIDENTIAL CARE ARE VIGOROUSLY PURSUED PRIOR TO ADMISSION INTO ANY TREATMENT FACILITY.

- A. The Minnesota State Legislature should help counties establish and fund preadmission screening programs for all publicly subsidized persons afflicted by mental illness, chemical dependency and mental retardation who are about to enter, residential facilities.
- B. The Minnesota Legislature should change present Minnesota statutes relating to employer-provided mandated benefits. Employers should not be required to cover inpatient stays for either chemical dependency or mental illness which exceed present statewide averages for length of stay in either of those areas.
- C. The U.S. Congress should extend its prospective reimbursement system to the treatment of alcoholism and mental illness.
- D. State and county governments and private insurers should put area hospitals on notice that they will not be reimbursed for medically unnecessary psychiatric or chemical dependency care provided to juveniles. Private insurers should institute rigorous utilization review programs in each of these areas.
- E. An overhaul of the juvenile court will lead to the imposition of a better screening system. Major changes are needed in the juvenile justice system to protect the rights and liberties of youth as well as to utilize residential care more appropriately. We suggest the following as first steps.
 - The Minnesota Legislature should remove status offenses from the jurisdiction of the juvenile court.

In 1982, the Minnesota Legislature removed status offenders from the delinquency category and allowed the police and schools to issue citations to juvenile offenders. The result has been that more, not fewer, of these cases are coming into the courts. And, the revised law still allows the court to use out-of-home placement as a response to these offenses (use of alcoholic substances, "uncontrollable behavior", and being "wayward"). This is unacceptable. Status offense are crimes which would not be punishable if committed by an adult. Neither should they be crimes when committed by young people. The effect of our recommendation would decriminalize this category of offenses, including such things as truancy, running away and the rest. Minors' use of alcohol should be treated separately.

We would prefer to see this class of problems handled by public or private nonprofit agencies rather than the courts. Freeing the juvenile court from the responsibility for handling such offenses should increase its capacity to spend more time on more serious cases.

- The Minnesota State Legislature should redefine the purpose of pre-trial detention and training schools and set criteria for their use. At a minimum,, the state should follow the detention standards of the National Advisory Commission on Juvenile Justice. Detention hearings should be held within 48 hours of admission, and preferably earlier. A judge should preside at these hearings, and juveniles should be represented by counsel. The only justification for pre-trial detention, so far as we are concerned, is to safely and humanely incarcerate those youths who constitute a clear and substantive threat to themselves or society at large or who are to be tried for crimes of person. The purpose of training schools is to incarcerate only those who have been convicted of such crimes.
- The Minnesota State Legislature should separate the judicial and administrative responsibilities of the state's juvenile courts. The juvenile court should be responsible for the dispensation of justice. It should not be responsible for the administration of the correctional/social service system designed to carry out its dispositions.

For the court to carry both of these roles appears to us and increasingly to others as a conflict of interest. Responsibility for services such as probation, detention and residential treatment should be a function of local county boards.

A useful distinction should be made between the judicial functions of sentencing and disposition. Juvenile court judges upon reaching a conclusion of guilt or innocence should be responsible for delivering a sentence based on the principle of proportionality. Judges should determine the length of the sentence. However, the actual placement decision for juveniles adjudicated for non-personal offenses should be jointly agreed upon by county personnel and the child's parents. After sentencing, but prior to disposition, the case worker and the child's parents should present a treatment plan to the court to assure it that its sentence will be carried out.

- The Minnesota State Legislature should require that in cases of child abuse, the offending parent be formally charged with a crime. Consideration should also be given to removing the parent from the home rather than the child. Charging spouses with crimes for battering their wives/husbands has been shown to be effective in lowering the incidence of such occurrences in Minneapolis and several other demonstration areas. Although someday child abuse may be seen as an illness, for now, this same approach should be taken with respect to abusive parents. Removing anyone from his/her home, whether parent or child, is a radical step and should only be taken when there is substantial evidence of direct or potential harm. The same insistence upon the civil liberties of young people must also govern actions with respect to their parents. But there will be instances where an abusive parent may need to be removed from the home. Our preference is that it be an abusive parent that is removed rather than a battered or abused child since current policies have the effect of blaming children for their own misfortunes.

- In instances of dependency and neglect, juvenile judges should give more consideration to placing a mediator in the home rather than removing the child.
- More use of diversion and restitution should be encouraged for juvenile offenders who do not have a long history of persistent property or violent crimes. A number of states including Utah, Massachusetts, Pennsylvania and Iowa have moved in this direction without encountering any greater risk to public safety.
- Finally, the Minnesota State Legislature should open up the possibility for non-judicial resolution of some juvenile cases. Community Dispute Resolution Centers, staffed by trained community volunteers and located in extra space in public facilities already exist in some communities and appear to make a useful contribution. Several recent legislative proposals could broaden their use. The existing proposals would allow the juvenile court to refer a child alleged or adjudicated to be a delinquent child, a habitual truant, runaway or juvenile petty offender to a community dispute resolution center. The court could refer the child prior to adjudication for case resolution or after adjudication, allowing the dispute resolution center to set the terms of restitution, reparation or community service requirements. Victims of crimes could opt to participate in the proceedings. Such centers could provide ways to lessen the caseload of the juvenile courts, and if properly supervised, could help communities resolve their own problems.

(NOTE: This recommendation was formulated prior to legislative action in the 1984 session. We commend the Legislature for their recent actions in this area and hope that more community dispute resolution centers will soon emerge.)

II. FEDERAL, STATE AND LOCAL PROGRAMS WHICH PAY FOR RESIDENTIAL CARE SHOULD BE CHANGED SO THAT PAYMENT FOR HOUSING IS SEPARATED FROM PAYMENT FOR SERVICE AND BOTH TYPES OF REIMBURSEMENT FOLLOW PEOPLE'S CHOICES OF PROVIDERS.

A. The U.S. Congress in its 1985 session should separate payment for housing from that of service in the following programs:

- 1) The Elderly - TITLE XIX, (Medicaid); TITLE XX OF THE SOCIAL SECURITY ACT; TITLE XVIII OF THE SOCIAL SECURITY ACT (Medicare)
- 2) The Mentally Retarded - TITLE XIX
- 3) The Mentally Ill - TITLE XIX; TITLE XX, TITLE IV-B; TITLE IV-C
- 4) Juvenile Justice - TITLE XX; TITLE XIX
- 5) The Chemically Dependent - TITLE XX; TITLE XIX (other federal sources such as NIDA, NIAAA, NIMH)

B. The Minnesota Legislature, in its 1985 session should separate payment for housing from that of service in the following programs:

- 1) The Elderly - the state's share of TITLE XIX (ie the 53% state match); General Assistance Medical Care (GAMC); the Catastrophic Health Expense Protection Program (CHEPP, and especially CHEPP - 2)
 - 2) The Mentally Retarded - Rule 52, CSSA, State Hospital Account
 - 3) The Mentally Ill - Rule 14, Rule 22, Rule 36, GAMC, CSSA, State Hospital Account
 - 4) Juvenile Justice - CSSA, Community Corrections Act
 - 5) The Chemically Dependent - Community Social Service Act (CSSA); the State Hospital Account administered by DPW; the State's share of Medicaid, GAMC and CHEPP
- C. Private entities such as third party payers (insurance companies), the United Way and local foundations should also separate payment for housing from service when providing reimbursement for residential care.
- D. The Minnesota State Legislature should pass a bill providing targeted wage subsidies to businesses which hire former employees of public residential facilities. These wage subsidies should account for the difference, if any, between what people were paid as state employees and the salaries available to them in the private sector.
- E. The Minnesota Legislature should authorize a reexamination of present rules and regulations governing the provision of residential care in Minnesota. Specifically:
- The Office of the Legislative Auditor should conduct an evaluation of state rules and regulations affecting residential care in Minnesota.
 - Both the Department of Public Welfare and the Department of Health should begin to apply regulations more selectively across the provider population. Those providers with good records of performance in quality of care and minimizing abuse should be allowed to meet somewhat less costly and restrictive standards. (The Interagency Board on Quality Assurance is moving in this direction in long-term care.) Where federal waivers are required to implement this recommendation, they should be sought.
 - The Minnesota Department of Health should, on a demonstration basis, create a "deregulated nursing home." The Department should determine, in consultation with existing providers which regulations should be waived. The demonstration should use an existing nursing home so as to forego any potential capital costs which might otherwise be affiliated with the project.

- The Minnesota Legislature should instruct both the Department of Health and the Department of Welfare to include, in any further legislation on rules and regulations, estimates of the cost to providers to comply with the proposed restrictions and the resulting impacts on residential rates.

DISCUSSION:

If policymakers decided to implement the changes suggested above the following impacts would likely occur:

- Separate markets would have been created for housing and service.
- An entirely new array of housing options would become available to consumers – effectively removing the "institutional bias" from the present system.
- An entirely new array of service options would become available to consumers – effectively removing the "medical bias" from the present system.
- Federal and state governments have historically placed housing programs for the disabled under health care expenditures. Our recommendations legitimize housing as a separate program.
- Residential providers will become more responsive to those who live in their facilities since consumers will now have distinct choices on where they live and from whom service is purchased. In this new environment, providers would need to respond to both of these markets.
- Many new opportunities for providers will be encouraged. In particular, providers will have incentives to unbundle care and deliver more of it outside of institutional walls. Providers will have incentives to do more with home care and may become interested in building congregate housing facilities. With reimbursement following consumers' choices, hospitals, nursing homes and other residential facilities will have incentives to establish "swing beds" for those who choose to stay on, temporarily.
- There will be no need for the state to go through the lengthy and difficult process of seeking waivers from federal programs to use existing monies in different ways. Separating payment for housing from payment for care should provide more flexibility.
- The future roles of residential providers – particularly state hospitals, state training schools and other juvenile correctional facilities would be determined not by political compromises but by the conscious decisions of the people they serve. Under this new system, patients or their surrogates could decide whether to stay or leave.

III. THE FEDERAL AND STATE GOVERNMENTS SHOULD PROVIDE PEOPLE IN NEED OF CARE WITH PROSPECTIVELY DETERMINED ALLOWANCES FOR HOUSING AND CARE.

- A. Housing allowances should be modeled after existing federal housing allowance programs with an extra stipend for transitional costs in case present tenants of residential facilities decide to live elsewhere.

An innovative federal housing allowance program operates on a co-payment arrangement. An eligible family pays a portion of its housing costs and receives a subsidy for the other portion, usually the difference between 30% of the family's income and a rent payment standard set by the Department of Housing and Urban Development (HUD). This allowance would need to be adjusted for the area and type of unit rented. Households must agree to housing inspections that ensure the units meet health and safety conditions.

The housing allowance program would use existing housing stock. And there is tremendous underutilized housing capacity in the metropolitan area which could potentially be adapted to the needs of those with functional disabilities. According to a 1982 Citizens League report, at least 60,000 new small rental units could be created in the Twin Cities by modifying existing housing in single family neighborhoods. Another 5,300 units could be added to existing apartment buildings in the two central cities of Minneapolis and Saint Paul, the League said. Finally, some 1,800 rental units in the region have been vacant for more than six months, according to the 1980 census. Many of these units could eventually be returned to the market for use by the disabled after substantial rehabilitation and conversion.

Housing allowances could be made available to anyone currently in a residential setting who could live independently and does not have a "home" to return to or to those who would otherwise be forced to enter a residential facility and is currently in need of shelter. Housing allowances could also be used by those who have a home to return to but whose home is in need of some rehabilitation in order to better facilitate the person's ambulatory needs.

- B. Service allowances should be determined prospectively based on the extent of people's functional impairment and providers' performance.

- 1) Public dollars should be allowed to vary among individuals depending upon their level of functional impairment.

(The Interagency Board on Quality Assurance is already developing a case-mix system for long-term care. The same principle could be applied across systems. As the state tries to create an FRG system it should build three factors into the construction of a particular reimbursement category: the degree to which physical assistance is necessary; the degree to which medical support is necessary and the need, if any, for personal supervision and or physical control.)

- 2) While reimbursement based on functional impairment seems most equitable to us as a general principle, policymakers should recognize that there may be cases in which the degree of functional impairment needs not result in higher costs.
- 3) Eventually, FRG's could be adjusted up or down at the end of each reimbursement period according to providers' performance in meeting pre-established prognoses. But this will require the development of much more sophisticated techniques than is true of the present state of the art. Someday, however, providers might receive additional reimbursement for containing costs, and for wellness or other rehabilitative activities leading to a decreased dependence on formal (paid) service provision.

In instance!; where providers failed to achieve pre-established goals, government could consider holding a portion (say 5-15%) of future reimbursement in escrow. If the providers performance increased, the entire escrowed sum might be returned to them. If not, a lesser sum would be returned.

IV. INDIVIDUALS SHOULD RECEIVE INCENTIVES TO USE HIGH QUALITY, LOW COST, PREFERRED PROVIDERS, REGARDLESS OF WHETHER THEIR CARE IS PROVIDED AT PUBLIC OR PRIVATE EXPENSE.

- A. Where individuals are found to be incapable of making service decisions on their own, family members, relatives and friends should make such decisions. Publicly funded guardians or conservators should be used only as a last resort.
- B. In order to compare costs from one residential facility to another and residential and non-residential costs, the State Legislature should require that all costs be publicly disclosed. This has already been done for nursing homes. It should also be done for the other systems.

Disclosed costs should be broken down into capital or housing costs and care costs. We urge the Minnesota Legislature to pass such a bill in its 1985 session with implementation to come from the state departments of Health and Welfare.

- C. Public costs for in-home care and non-residential care should be kept at or below the costs of a residential facility.
- D. Within public and private systems, people should be given incentives to use "preferred providers" - those providers whose charges are at or below community price norms for a given service. People should also be able to choose higher cost providers, but if they do so, they should be required to pay the difference in price out of pocket.
- E. Access to publicly funded home care and non-residential care should be limited to those who currently receive such services, those who are able to be discharged from a facility or those who are about to enter one. Other [populations should be phased-in over time as residential use and costs subside.

V. PRIVATE FINANCIAL MECHANISMS SHOULD BE DEVELOPED TO ASSIST THE ELDERLY IN MEETING THEIR FINANCIAL OBLIGATIONS, DEVELOP A SENSE OF PERSONAL AND FAMILY RESPONSIBILITY AND TO DEFRAY SOME PUBLIC COSTS.

Of all of the systems which we have examined, the costs of caring for the elderly are the most extensive and rapidly growing. Given present demographic projections about likely increases in the elderly population in the years ahead, it is now apparent that the public sector will be unable, by itself, to afford these costs. Many of the assumptions behind current programs must be challenged. Perhaps Social Security and Medicare will need to be "means tested". Perhaps payments to Medicaid vendors should be made on a prepaid, prospective basis. Perhaps, the house should be included as part of the eligibility requirements for MA. Almost certainly the public sector's incapacity to fully fund these programs will demand a more targeted approach and the direct financial involvement of the elderly and their families.

As we move into this new era, our primary objectives should be the following:

- * Public programs should address themselves first, and foremost, to the needs of those with the least means.
- * Changes will be needed in public programs serving the elderly to set limits on reimbursement (in total and on an individual case basis) and re-examine existing eligibility requirements.
- * New private financial approaches will be needed to supplement public efforts. The focus of such efforts should be to help people, prior to the onset of old age, set aside sufficient assets for their retirement years and effectively manage those assets after retirement.
- * Elderly people with means should be expected to finance much of their care themselves, - either through new kinds of insurance mechanisms or through the creative management of their assets. Only after the capacity for personal maintenance is exhausted should family members and the public be expected to pay for care.
- * Over time, the issue of the family's financial responsibility for the care of elderly members will grow in importance. The first type of family contribution to be made should involve the equity in elderly people's homes as opposed to direct financial contributions by their children even though home equity conversion will affect the size of the estate which may be left to the heirs.

While they do not represent recommendations at this time, the following set of ideas flow from the objectives above and offer a stimulating basis for further community discussion and debate:

- A. Minnesota insurance companies could review the potential for developing long-term care insurance as a marketable product. Our goal should be to encourage seniors to pay more of their own costs but at the same time, find ways to help them avoid catastrophic costs. The development of a market for long term care insurance would accomplish those objectives. But we must be careful in developing new third party arrangements not to make the same mistakes that have plagued the acute care system and have lead to staggering cost control problems. Such problems could be avoided if insurers would offer policies on an indemnity basis, paying a fixed amount per day with a maximum payable limit. Policies should cover both nursing home care and home care with incentives to substitute the latter for the former. Individuals should be given incentives to use low-cost, high quality "preferred providers". (For a useful prototype of the kinds of insurance packages we hope to encourage, insurers should refer to the work of Dr. Mark Meiners of the National Center for Health Policy Research, specifically, his most recent article in Health Affairs - "The Case for Long-Term Care Insurance.")
- B. Minnesotans could be encouraged to create IRA's and other creative savings mechanisms prior to retirement in order to increase their net assets and retirement income.
- C. Instead of encouraging elderly people to spend down their assets, Minnesota's Medicaid program could encourage people approaching retirement age to conserve their assets in order to preserve their financial independence.
 - * For those people already living in nursing homes and dependent upon MA, this suggestion would bring no further changes save the previously discussed separation of reimbursement for service and housing.
 - * For those people however, aged 60 and over, who will become eligible for MA after July 1, 1986, the Minnesota Legislature could provide an annual sum with which to purchase long-term care insurance from private insurers. The amount of this sum could be capitated in advance and could be accompanied by a small consumer co-pay.
 - * Minnesota's state MA eligibility standards could be modified to include the home as an asset, in those instances where the circumstances will not force an able-bodied spouse into a nursing home.

But rather than simply placing a lien on the home of the elderly person as was done in the past, the state could offer the individual the option of entering into a split-equity arrangement. Such arrangements could be administered by the state Housing and Finance Agency. In return for a share of the equity in the person's house and its future appreciation, the state would provide monthly income payments, plus a deferral of all property taxes until after the person's death or sale of the home.

This approach could be advantageous since government could employ a relatively low required rate of return (just high enough, say, to earn its borrowing rate plus a margin for administrative costs) and thereby pay more generous annuities than private institutions. Ownership of individual houses by State government could be used as a social planning tool. Government could integrate its split equity operations with neighborhood renewal or development plans. Family farms might be preserved. Or it could use the program to promote racial integration, provide housing for low-income families at below market rate prices or use the houses as group homes for the disabled.

- * The Minnesota Department of Public Welfare could analyze the likely impacts of the proposed split-equity program on low-income persons eligibility for other state and federal social welfare programs. (Especially SSI.) The Department should then develop permissive legislation allowing recipients to gain from such transfers without endangering their eligibility.

- D. The concept of Home-Equity Conversion has a great deal of potential for supplementing elderly people's retirement income and could be an integral part of the evolving policy framework concerning the elderly.

The income-generating potential stemming from home equity conversion has recently been well documented by research from the Brookings Institution. Many areas around the country have investigations underway regarding the applicability of this concept to local needs. Similiar investigations are needed here. We are encouraged by findings that the poorest homeowners may have the most to gain from such plans and the fact that the Twin Cities has a substantial advantage relative to the rest of the country by virtue of its high rate of homeownership.

However, we are uncertain now, of whether home equity conversion should remain solely a private tool or whether the public sector should assist by developing useful prototypes. Perhaps this is something that more metropolitan area banks should look into. Perhaps some local foundations would be interested in furthering this concept. Perhaps the Metropolitan Council could create a region-wide non-profit entity to experiment with the idea.

Regardless of who ultimately develops the idea, it could:

- Offer a variety of different kinds of Home Equity Loans which are tailored to meet the needs of the region's seniors.
- Provide a financial counseling component to seniors interested in Home Equity Conversion. Financial institutions with a direct stake in the outcome of such decisions should pay for independent financial counseling sessions for interested seniors. (Likewise, it would also be helpful if organizations such as the Metropolitan Senior Federation assumed the role of helping their members evaluate the merits of various home equity conversion plans.)
- Develop a home equity payment account to assist seniors in paying for in-home services.
- Develop home equity construction loans to finance congregate, cooperative, or condominium housing for the elderly. The idea would be to pay for the construction costs with the aggregate proceeds of short-term loans taken out by the eventual residents on the homes they will vacate. The loans are paid off when the homes are sold. The sellers then move into the housing financed by their former homes and become equity owners in the new facilities.

This would be beneficial because ultimately, there is no way every elderly person can receive services in their homes. Congregate housing arrangements offer the potential for significant improvements in economy and efficiency of service provision and a means of overcoming social isolation.

EFFECTS OF OUR RECOMMENDATIONS ON THE ELDERLY.

FEATURES OF THE PRESENT	PROPOSED CL SYSTEM
1) THE HOUSING FUNCTION AND THE CARE FUNCTION ARE COMBINED.	1) THE HOUSING FUNCTION AND THE CARE FUNCTION ARE SEPARATED.
2) FUNDING DICTATES WHERE SERVICE WILL BE DELIVERED.	2) INDIVIDUAL DICTATES WHERE SERVICE WILL BE DELIVERED. FUNDING FOLLOWS PEOPLES" SERVICE CHOICES.
3) MIX OF OPEN-ENDED AND PROSPECTIVE REIMBURSEMENT. NO INCENTIVES BASED ON PROVIDER PERFORMANCE,	3) PROSPECTIVE REIMBURSEMENT. PERFORMANCE-BASED INCENTIVES FOR PROVIDERS
4) NO INCENTIVES FOR INDIVIDUAL TO CHOOSE LOW COST, HIGH QUALITY, PREFERRED PROVIDERS.	4) INDIVIDUALS HAVE INCENTIVES TO USE PREFERRED PROVIDERS.
5) ELIGIBILITY FOR PUBLIC PROGRAMS LEADS TO FINANCIAL DEPENDENCY ON THE STATE, HIGHER COSTS TO TAXPAYERS.	5) ELIGIBILITY FOR PUBLIC PROGRAMS HELPS TO SUSTAIN FINANCIAL INDEPENDENCE, LOWERS TAXPAYERS COSTS.
6) NO PRIVATE MECHANISMS TO HELP THE ELDERLY AVOID CATASTROPHIC COSTS, MAINTAIN FINANCIAL INDEPENDENCE.	6) PRIVATE MECHANISMS SUCH AS LONG-TERM CARE INSURANCE, HOME EQUITY CONVERSION HELP THE ELDERLY PAY FOR THEIR OWN COSTS.
7) ALTHOUGH PREADMISSION SCREENING GIVES PEOPLE A CHOICE BETWEEN HOME CARE AND NURSING HOME CARE, PEOPLE HAVE ONLY A LIMITED ABILITY TO LEAVE THE N. HOME AND LIVE INDEPENDENTLY.	7) PEOPLE'S ABILITY TO LEAVE THE NURSING HOME AND LIVE INDEPENDENTLY IS IMPROVED.
8) PRESENT SYSTEM OFFERS FEW CHOICES TO THOSE WHO DESIRE OR MUST LIVE IN A NURSING HOME.	8) NEW CHOICES ARE AVAILABLE TO N. HOME RESIDENTS SUCH AS CONTRACTING OUT, OWNING A SHARE OF THE N. HOME.
9) FEW ALTERNATIVES TO NURSING HOMES. NURSING HOMES HOUSE SOME PEOPLE WHO COULD LIVE INDEPENDENTLY AT THE SAME TIME THAT THERE IS MORE DEMAND FOR NURSING HOME BEDS THAN SPACE AVAILABLE.	9) CREATES ALTERNATIVES TO NURSING HOMES. IF LESS DISABLED LEAVE, EXTRA SPACE AVAILABLE. FOR NEEDY. OPENS UP THE N. HOME MARKET.

EFFECTS OF OUR RECOMMENDATIONS ON THE MENTALLY RETARDED.

FEATURES OF THE PRESENT SYSTEM	PROPOSED CL SYSTEM
1) MOST PUBLIC DOLLARS TIED TO INSTITUTIONS SUCH AS STATE HOSPITALS, ICF-MR'S.	1) MOST PUBLIC DOLLARS TIED TO INDIVIDUALS,
2) FUNDING SOURCES DICTATE WHERE PEOPLE LIVE, CONSEQUENTLY, MANY LIVE IN STATE HOSPITALS ICF-MR'S WITH FEW PROSPECTS FOR LIVING IN LESS RESTRICTIVE SETTINGS.	2) INDIVIDUALS OR GUARDIANS DICTATE WHERE THEY LIVE. PEOPLE MAY LEAVE THESE FACILITIES IF THEY CHOOSE.
3) REIMBURSEMENT MECHANISMS TEND TO DISCOURAGE DEINSTITUTIONALIZATION, INDEPENDENT LIVING.	3) REIMBURSEMENT MECHANISMS PROMOTE DEINSTITUTIONALIZATION, INDEPENDENT LIVING.
4) REIMBURSEMENT MECHANISMS ENCOURAGE FAMILIES TO PLACE MR CHILDREN IN RESIDENTIAL FACILITIES.	4) REIMBURSEMENT MECHANISMS ARE FLEXIBLE ENOUGH TO ALLOW FAMILIES TO CARE FOR THEIR CHILDREN AT HOME.
5) NO INCENTIVES TO USE LESS RESTRICTIVE, LESS COSTLY OPTIONS. AS A RESULT, TAXPAYERS PAY MORE.	5) INCENTIVES TO USE LEAST RESTRICTIVE, LOWER COST OPTIONS. TAXPAYERS PAY LESS FOR BETTER SERVICE.
6) STATE MAINTAINS DUPLICATIVE, TWO TIERED SYSTEM OF STATE HOSPITALS AND COMMUNITY FACILITIES.	6) AFFORDS THE OPPORTUNITY TO REDUCE CAPACITY OF THE STATE HOSPITAL SYSTEM AND THE COMMUNITY RESIDENTIAL SYSTEM.
7) VIRTUALLY NO SCREENING MECHANISMS IN PLACE.	7) SCREENING MECHANISMS IN PLACE.
8) REIMBURSEMENT SYSTEM IS OPEN-ENDED, FEE FOR SERVICE. FEW INCENTIVES FOR HIGH QUALITY PROVIDERS.	8) REIMBURSEMENT SYSTEM IS LIMITED, PROSPECTIVE. SOME \$ TIED TO PERFORMANCE.
9) PEOPLE HAVE NO INCENTIVES TO USE HIGH QUALITY, LOW-COST, PREFERRED PROVIDERS.	9) PEOPLE HAVE INCENTIVES TO USE PREFERRED PROVIDERS.
10) PEOPLE HAVE FEW SERVICE OPTIONS WITHIN THE GROUP HOME SETTING.	10) PEOPLE HAVE NEW CHOICES SUCH AS CONTRACTING OUT OWNING A SHARE OF THE HOME

EFFECTS OF OUR RECOMMENDATIONS ON THE MENTALLY ILL

FEATURES OF THE PRESENT SYSTEM	PROPOSED CL SYSTEM
1) NO SCREENING MECHANISMS IN PLACE.	1) SCREENING MECHANISMS IN USE
2) MOST PUBLIC AND PRIVATE DOLLARS TIED PUBLIC AND PRIVATE HOSPITALS. AS A RESULT, PLACEMENTS FOLLOW AVAILABLE FUNDING SOURCES.	2) MOST PUBLIC AND PRIVATE DOLLARS FOLLOW INDIVIDUALS OR GUARDIANS CHOICE OF TREATMENT FACILITY.
3) BECAUSE REIMBURSEMENT TIED TO HOSPITALS, COMMUNITY AND NON-RESIDENTIAL OPTIONS ARE UNDEVELOPED.	3) SEPARATING REIMBURSEMENT FOR HOUSING FROM SERVICE SHOULD HELP TO DEVELOP COMMUNITY AND NON-RESIDENTIAL SYSTEMS.
4) PERPETUATES EXCESS CAPACITY IN BOTH STATE HOSPITAL SYSTEM AND THE "COMMUNITY, RESIDENTIAL FACILITIES.	4) AFFORDS THE OPPORTUNITY TO REDUCE EXCESS CAPACITY IN BOTH SYSTEMS.
5) UNLIMITED, FEE FOR SERVICE REIMBURSEMENT. NO PERFORMANCE INCENTIVES FOR PROVIDERS.	5) LIMITED, PROSPECTIVE REIMBURSEMENT. PERFORMANCE INCENTIVES FOR PROVIDERS.
6) INDIVIDUALS HAVE NO INCENTIVES TO USE LOW COST, PREFERRED PROVIDERS	6) INCENTIVES TO USE HIGH QUALITY, PREFERRED PROVIDERS

EFFECTS OF OUR RECOMMENDATIONS ON THE CHEMICALLY DEPENDENT

FEATURES OF THE PRESENT SYSTEM	FEATURES OF THE PROPOSED CL SYSTEM
1) PREADMISSION SCREENING NOT USED.	1) PREADMISSION PROGRAMS IN PLACE.
2) OPEN ENDED, FEE FOR SERVICE REIMBURSEMENT.	2) PROSPECTIVE REIMBURSEMENT.
3) NO INCENTIVES TO USE LESS COSTLY, EQUALLY EFFECTIVE FORMS OF TREATMENT.	3) INCENTIVES TO USE PREFERRED PROVIDERS, WHETHER IN-PATIENT OR OUT-PATIENT.
4) COUNTIES HAVE INCENTIVES TO USE STATE HOSPITALS FOR PLACEMENTS.	4) DECISIONS MADE BY INDIVIDUALS NOT COUNTIES.
5) GROWING SUSPICION OF IN-PATIENT OVERCAPACITY.	5) AFFORDS THE OPPORTUNITY TO REDUCE OVERCAPACITY.
6) SUSPICION THAT HOSPITALS MAXIMIZE INPATIENT CD IN ORDER TO FILL BEDS.	6) APPLYING DRG, PROSPECTIVE REIMBURSEMENT AND TIGHTER SCREENING SHOULD CURB WHATEVER ABUSE NOW EXISTS.
7) HOUSING AND CARE PART OF THE SAME PACKAGE.	7) ALLOWS HOUSING AND CARE TO BE "UNBUNDLED".

EFFECTS OF OUR RECOMMENDATIONS ON THE JUVENILE JUSTICE SYSTEM.

FEATURES OF THE PRESENT SYSTEM	PROPOSED CL SYSTEM
1) STATUS OFFENSES (TRUANCY, USE OF ALCOHOL, RUNNING AWAY, ETC.) ARE CRIMES.	1) STATUS OFFENSES ARE DECRIMINALIZED. (ALCOHOL ABUSE TREATED SEPARATELY.)
2) JUVENILE COURT HAS JURISDICTION OVER STATUS OFFENSES.	2) JUVENILE COURT STRIPPED OF JURISDICTION FOR STATUS OFFENSES.
3) TOO MUCH USE OF PRE-TRIAL DETENTION, TRAINING SCHOOLS.	3) USE OF TRAINING SCHOOLS, PRE-TRIAL DETENTION LIMITED TO MOST SERIOUS OFFENDERS.
4) JUVENILE COURT HAS BOTH JUDICIAL AND ADMINISTRATIVE RESPONSIBILITIES. (ADMINISTRATIVELY, THE COURT OPERATES SERVICES SUCH AS PROBATION, DETENTION AND RESIDENTIAL TREATMENT.)	4) RESPONSIBILITY FOR BOTH OF THESE AREAS RAISES THE QUESTION OF CONFLICT OF INTEREST. TWO FUNCTIONS SHOULD BE SEPARATED. COURT RESPONSIBLE FOR JUSTICE. COUNTY BOARD RESPONSIBLE FOR ADMINISTRATION.
5) JUVENILE COURT ISSUES SENTENCES, DICTATES PLACEMENTS. (IN THE ADULT SYSTEM, THE COURT DOES NOT DETERMINE PLACEMENTS.)	5) JUVENILE COURT ISSUES SENTENCES. PLACEMENT IS A JOINT DECISION OF COUNTY AND PARENTS.
6) JUVENILES OFTEN UNREPRESENTED BY COUNSEL.	6) JUVENILES REPRESENTED BY COUNSEL.
7) CHILDREN REMOVED FROM HOME IN INSTANCES OF PARENTAL ABUSE.	7) PARENTS CHARGED WITH A CRIME. PARENTS, RATHER THAN CHILD REMOVED FROM HOME.
8) CHILDREN OFTEN REMOVED FROM THE HOME IN CASES OF DEPENDENCY/NEGLECT.	8) MEDIATOR PLACED IN THE HOME RATHER THAN PLACING THE CHILD OUTSIDE HOME.
9) NO OPPORTUNITIES FOR NON-JUDICIAL CASE RESOLUTION.	9) OPPORTUNITIES FOR NON-JUDICIAL CASE RESOLUTION BY COMMUNITY DISPUTE RESOLUTION CENTERS.
10) RESIDENTIAL TREATMENT OVERUSED.	10) NON-RESIDENTIAL OPTIONS MORE READILY AVAILABLE

WORK OF THE COMMITTEE

The Citizens League Board of Directors programmed a study on institutionalization in June, 1982. The committee began its work on November 15, 1982 and completed final action on its report on March 28, 1984. Approximately 87 people signed up for the committee. Of these, approximately 23 people participated, in varying degrees in the preparation of the final report. They are:

Emily Anne Staples, Chair	Merle Mark M.D.
Susan Abderholden	Verla Nelson
Sonia Cairns	David Piper
Ward Edwards	Rip Rapson
Leo Feider	Carl Reuss
James Gavisser	Peter Sipkins
Sally Graven	Lorraine Teel
Virginia Greenman	Peter Thoreen
Mary Healy	Jana Wahoski
Dr. Helen Holmes	Carol Watkins
Dr. Marilyn Jackson-Beeck	Lois Charlebais
LaRhae Knatterud	(representing Daphne Krause)

The committee was assisted by David Hunt of the Citizens League research staff and Char Greenwald of the support staff.

The Citizens League Board of Directors gave the committee the following charge:

"Examine the question of relying more in coming years on conventional living settings, as distinguished from institutions, in providing care for people, either because the institutional approach may be less satisfactory for the benefit of the individual or because fewer funds will be available to support institutionalization."

The Board's charge asked the committee to "look at the extent of institutionalization in various categories, for example, nursing homes for the elderly." In each case, the committee was to "understand the rationale for taking the institutional solution and ..., review information on how well the experience has turned out, including whether ... the institutional approach has been taken to suit the convenience of the funding source or the needs of service providers." In instances where the case for providing an institutional solution is not strong, the committee was asked to explore whether there were ways of doing a better job by "utilizing more conventional living arrangements, such as private homes."

The committee's charge from the Board clearly indicated an interest in both the human and financial impacts of institutional care. The charge noted that certain factors - such as a decline in the availability of Medicaid - could mean that eligibility requirements would be tightened, thereby reducing the amount of institutionalization in coming years. The committee was asked to examine what options should be available to those persons for whom reimbursement for care in institutions no longer would be provided.

In attempting to address its charge, the committee met 30 times for an average of 2 hours per session. A total of 34 resource persons appeared before the committee, lending their time and expertise to its deliberations. They included:

SUE ABDERHOLDEN, Associate Director, Minnesota Association of Retarded Citizens
MARILYN JACKSON-BEECK, P.h.D, formerly Coordinator of Health Services Information at Blue Cross/Blue Shield State Senator
LINDA BERGLIN, Chair, Senate Health and Human Services Committee
LEONARD BOCHE, Executive Director, Minnesota Association of Treatment Programs
CALVIN CLARK, member, Board of Directors, Minnesota Council on Chemical Dependency and Hazelden, former Citizens League staff member
PABLO DAVILLA, Program Manager of Family and Children's Services, Community Human Services Department, Ramsey County
TOM DEWAR, Senior Fellow, Hubert H. Humphrey Institute of Public Affairs University of Minnesota
NANCY ANDERSON EUSTIS, Professor, Hubert H. Humphrey Institute of Public Affairs, University of Minnesota
RICHARD ERICKSON, Executive Director, Minnesota Citizens Council on Crime and Justice
KERRY FINE, Legislative Analyst, Minnesota House of Representatives
ANN GJELTEN, Director of Health Economics, Minnesota Blue Cross/Blue Shield
ANN JAEDE, Manager of Criminal Justice Program, State Planning Agency
MARGARET JAMIESON, Director of Nursing, Group Health Inc.
RON JOHNSON, Division of Corrections Services, Amherst Wilder Foundation
CINDY POLICH-KOECK, Consultant
WILLIAM KIRCHNER, former State Senator, Chairman and VP, Richfield Bank and Trust Company
MARILYN LEE, Amherst Wilder Foundation
JAY LINDGREN, Executive Officer for Juvenile Release, Minnesota Department of Corrections
RICHARD MAMMEN, former Executive Director, Katahdin Treatment Center; currently President, Duke's Dogs
JERRY MEIER, Vice President, Altcare Corporation
LUVERNE MOLBERG, President, Webster Institute
DARLENE OLSON, Chair, Government Affairs Committee, Minnesota Association of Retarded Citizens
SHARON PATTEN, PH.D., Hubert H. Humphrey Institute of Public Affairs, University of Minnesota
MARJEE RIGHEIMER, Partner, President, Nursing Care Services Inc.
RACHEL RUSTAD, Administrator, Stevens Square
IRA SCHWARTZ, Senior Fellow, Hubert H. Humphrey Institute of Public Affairs, University of Minnesota
JOHN SELSTAD, Director of SHMO, Ebenezer Society
SHARON STUART, Program Analyst, Association of Residences for the Mentally Retarded
REPRESENTATIVE JAMES SWANSON, Chair, House Health, Welfare and Corrections Committee
CINDY TURNURE, Ph.D., Director of Alcohol and Drug Abuse Programs, Minnesota Department of Public Welfare

MARGE WHERLEY Residential Program Consultant, Mental Health Division,
Hennepin County COLLEEN WIECH, Ph.D., Executive Director, Minnesota
Governor's Planning Council on Developmental Disabilities
LYLE WRAY, Court Appointed Monitor, Welsch versus Levine Consent Decree PETER
WYCKOFF, Executive Director, Metropolitan Senior Federation

There were three phases of the committee's work. The first phase was devoted primarily to testimony from key resource people from the community. In this phase the committee faced the difficult task of deciding which populations to include in its study. Testimony was received on five populations including the elderly, the mentally ill, the mentally retarded, the chemically dependent and the juvenile justice and child welfare systems. At this juncture, many committee members felt overwhelmed by the information they had received on the various systems and some were beginning to wonder whether the committee's charge was too broad. A staff draft of findings highlighting the similarities between the populations and further internal committee discussion helped people recognize that a common set of issues existed across populations.

The second phase of the committee's work was concerned with issue identification. Committee discussions focused on issues which cut across populations. After these issues were identified, staff developed issue papers for each question. Typically, an issue paper would pose a policy question in need of resolution, offer pertinent background information, and pose several alternatives for committee discussion. Committee members were free to select any of the alternatives or suggest their own.

The third phase of the committee's work, issue resolution, was the outcome of the committee's discussion of the issue papers. From these discussions, the basic framework for committee conclusions and recommendations emerged. Equipped with preliminary answers to policy questions, staff was asked to begin drafting a report. Further committee discussion of these drafts served to refine the recommendations into their present form.

Committee members were united in their support of this report although some members took exception to particular positions of the majority. No one chose to submit a minority report.

The report was submitted to the Citizens League Board of Directors for their consideration on April 25th, 1984.

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WHAT THE CITIZENS LEAGUE IS

Formed in 1952, the Citizens League is an independent, non-partisan, nonprofit, educational corporation dedicated to understanding and helping to solve complex public problems of our metropolitan area.

Volunteer research committees of the Citizens League develop recommendations for solutions after months of intensive work.

Over the years, the League's research reports have been among the most helpful and reliable sources of information for governmental and civic leaders, and others concerned with the problems of our area.

The League is supported by membership dues of individual members and membership contributions from businesses, foundations and other organizations throughout the metropolitan area.

You are invited to join the League, or, if already a member, invite a friend to join. An application blank is provided for your convenience on the reverse side.

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WHAT THE CITIZENS LEAGUE DOES



RESEARCH PROGRAM

- Four major studies are in progress regularly.
- Each committee works 2½ hours every other week, normally for 6-10 months.
- Annually over 250 resource persons made presentations to an average of 25 members per session.
- A fulltime professional staff of eight provides direct committee assistance.
- An average in excess of 100 persons follow committee hearings with summary minutes prepared by staff.
- Full reports (normally 40-75 pages) are distributed to 1,000-3,000 persons, in addition to 3,000 summaries provided through the CL NEWS.

CL NEWS

- Four pages; published every two weeks; mailed to all members.
- Reports activities of the Citizens League, meetings, publications, studies in progress, pending appointments.
- Analysis data and general background information on public affairs issues in the Twin Cities metropolitan area.

PUBLIC AFFAIRS ACTION PROGRAM

- Members of League study committees have been called on frequently to pursue the work further with governmental or nongovernmental agencies.
- The League routinely follows up on its reports to transfer, out to the larger group of persons involved in public life, an understanding of current community problems and League solutions.

PUBLIC AFFAIRS DIRECTORY

- A 40-page directory containing listings of Twin Cities area agencies, organizations and public officials.

COMMUNITY LEADERSHIP BREAKFASTS LANDMARK LUNCHEONS QUESTION-AND-ANSWER LUNCHEONS

- Public officials and community leaders discuss timely subjects in the areas of their competence and expertise for the benefit of the general public.
- Held from September through May.
- Minneapolis breakfasts are held each Tuesday from 7:30 - 8:30 a.m. at the Lutheran Brotherhood.
- St. Paul luncheons are held every other Thursday from noon to 1 p.m. at the Landmark Center.
- South Suburban breakfasts are held the last Thursday of each month from 7:30 - 8:30 a.m. at the Lincoln Del, 494 and France Avenue South, Bloomington.
- An average of 35 persons attend the 64 breakfasts and luncheons each year.
- Each year several Q & A luncheons are held throughout the metropolitan area featuring national or local authorities, who respond to questions from a panel on key public policy issues.
- The programs attract good news coverage in the daily press, television and radio.

SEMINARS

- At least six single-evening meetings a year.
- Opportunity for individuals to participate in background presentations and discussions on major public policy issues.
- An average of 75 person attend each session.

INFORMATION ASSISTANCE

- The League responds to many requests for information and provides speakers to community groups on topics studied.
- A clearinghouse for local public affairs information.

Citizens League non-partisan public affairs research and education in the St. Paul-Minneapolis metropolitan area. **84 S. 6th St., Minneapolis, Mn. 55402 (612) 338-0791**

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RECENT CITIZENS LEAGUE STATEMENTS

(Statements, when available, are free)

Statement to Legislative Study Committee on Metropolitan Transit	12/15/83
Statement to Governor's Tax Study Commission	11/22/83
Statement to Minnesota's Highway Study Commission	9/29/83
Statement on the Metropolitan Council's Proposed Interim Economic Policies	8/29/83
Statement to Mpls. Charter Commission: Proposal to have Mayor as non-voting member of Council	8/11/83
Statement to Metropolitan Council and Richard P. Braun, Commission of Transportation on Preferential Treatment for Transit in Expansion of I-35W	7/21/83
Statement to Members, Steering Committee on Southwest/University Avenue Corridor Study	7/19/83
Statement to Commission on the Future of Post-Secondary Education in Minnesota	6/22/83
Statement to the Metropolitan Health Board	6/20/83
Appeal to the Legislature and the Governor	4/26/83
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